# STUDENT-PATIENT INTERACTIONAL PRACTICES IN A MALAYSIAN DENTAL FACULTY

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# STUDENT-PATIENT INTERACTIONAL PRACTICES IN A MALAYSIAN DENTAL FACULTY

## ABSTRACT

This study explores interactional practices of third-year dental students in Faculty of Dentistry, University Malaya (FoDUM) with their patients, and patients' satisfaction in the engagement. It also aims to expand the growing literature on dental student-patient interaction and to enhance our understanding of doctor-patient interactions in localized and specialized site of engagement. 18 students and 10 patients participated in this study. Using a discourse analytical approach, this qualitative study incorporates Sarangi's (2010) Activity Analysis on structural mapping to discover the structures involved in an accessible data type before injecting other relevant discourse and conversation tools to inspect the participants' interactional practices during the entire engagement. Linguistic variations are found exhibited amongst the multilingual student-patient community in the setting as part of the practices in the setting. The study also reveals that the students are still confronting interactional challenges despite high satisfaction reported by all patients. The students' needs and wants are also queried for to anticipate communicative issues in dental practices. One limitation of this study is its generalizability.

Keywords: *interactional practices, third-year dental students, clinical practices, satisfaction, discourse analysis, communicative challenges*

# *PRAKTIS INTERAKSI ANTARA PELAJAR-PESAKIT DI FAKULTI PERGIGIAN MALAYSIA*

## *ABSTRAK*

*Kajian ini bertujuan meneroka praktis interaksi dalam rawatan klinikal antara pelajar pergigian tahun ketiga di Fakulti Pergigian, Universiti Malaya bersama pesakit. Ia bagi mengenal pasti tahap kepuasan pesakit dengan perkhidmatan yang diberikan oleh pelajar sepanjang sesi rawatan. Kajian ini juga bermatlamat mengembangkan kesusasteraan yang semakin meningkat mengenai interaksi, serta meningkatkan pemahaman antara pelajar dan pesakit pergigian secara khusus sepanjang sesi berkenaan. Seramai 18 pelajar dan 10 pesakit terlibat dalam kajian ini. Menggunakan wacana pendekatan analitik, kajian kualitatif ini menggabungkan satu kaedah dari Aktiviti Analisis Sarangi (2010) dalam konteks penglibatan antara pelajar dan pesakit. Ini adalah untuk mengkaji struktur yang terlibat sebelum mengaplikasikan wacana dan metodologi interaksi yang relevan dalam bidang fokus kajian. Berdasarkan aspek linguistik, terdapat kepelbagaian dalam praktis interaksi antara pesakit dan pelajar yang menggunakan bahasa berbeza. Kajian mendedahkan bahawa pelajar masih berdepan dengan beberapa cabaran dari segi interaksi meskipun laporan akhir mendapati mereka berpuas hati dengan reaksi daripada semua pesakit. Dapatan kajian akan menyumbang kepada penambahbaikan terutama dalam aspek interaksi antara pesakit dan pelajar pada masa depan. Batasan dalam kajian adalah set data yang terhad, justeru simpulan keseluruhan daripada penemuan kajian tidak boleh diaplikasikan di seluruh Fakulti Pergigian di Malaysia buat ketika ini.*

Kata Kunci: *praktis interaksi, pelajar pergigian tahun tiga, amali klinikal, tahap kepuasan, analisis wacana, cabaran komunikatif*

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Finally, I solely dedicate my work to my family.

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# LIST OF SYMBOLS AND ABBREVIATIONS

| | | |
|---|---|---|
| SO | : | Student-Operator |
| SA | : | Student-Assistant |
| P | : | Patient |
| UM | : | University of Malaya |
| FoDUM | : | Faculty of Dentistry, University of Malaya |
| UKM | : | Universiti Kebangsaan Malaysia |
| DA | : | Discourse Analysis |
| AA | : | Activity Analysis |
| EnD | : | Examination and Diagnosis |

# CHAPTER 1: INTRODUCTION

## 1.1. Introduction

Effective interaction is crucial for both healthcare providers and patients in increasing the effectiveness of treatment, patient's adherence and satisfaction level of the clinical engagement (Matusitz & Spear, 2014; Ranjan, Kumari & Chakrawarty, 2015; Memarpour, Bazrafkan & Zarei, 2016). Additionally, there is growth of literature on medical student/doctor-patient talk for interactional improvement purposes. Previous literature have examined best practices that can satisfy every active agent's interactional needs and wants (Ong et. al, 1995; Fong Ha & Longnecker, 2010). Similarly, other researchers have shown an interest in dental research, particularly on interaction between dentist and patient, in recent years (Carey, Madill & Manogue, 2010; Salmon & Young, 2011; Wener, 2011; Memarpour, 2016). However, an investigation from existing scholarly dental educational articles and academic research reveals that there is not much literature done on the interactional skills/verbal exchanges between novice dental students and actual patients in relation to patient satisfaction in clinical engagements (Dan O'Hair & Kreps, 2013). This study aims to contribute to the growing literature on dental educational research by examining the nature of interactional norms amongst dental students and their patients in a Malaysian university dental training centre as part of their professional practice. This research also seeks to address the issue that has been of interest amongst the Faculty of Dentistry, University of Malaya (FoDUM) on improving the quality of their dentistry educational practices in actual clinical settings.

Holden (2011) asserts that despite being competent in terms of medical knowledge, medical students generally find it difficult to express clinical thoughts in spoken interaction (Giroldi et. al, 2015). Benbassat and Baumal (2002) also address the issue on the importance of students' interactional skills in clinical practices when they

query patient's concerns, emotions, needs and wants at a chair/bedside. New students are also expected to talk "like a real doctor" (Sarangi & Roberts, 1999, p.66) and to interact efficiently and display awareness and sensitivity of cultural, gender and ethnic differences.

Students need to deploy appropriate strategies to determine their patients' involvement, adherence, perceptions, overall the predictors to their health outcomes and rating levels of satisfaction with the engagement (Ong et al., 1995; Silverman, Kurtz & Draper, 2005; Rider & Keefer, 2006; Diette et. al 2007; Rijssen et al., 2009; Fongha, Longnecker & Anat, 2010; Collins, Schrimmer, Diamond et. al., 2011; Weiner, 2012; Al-Mobeeriek, 2012; Gonzalez, Abu Kasim, Naimie, 2013; Foronda, MacWilliams & McArthur, 2016). Being able to display communicative competence contributes towards projecting the students' professional identity as well as ensuring the quality of care. As Chang, Park and Kim (2013) posit, the determinant of quality in this setting is both associated with the doctors' interactional styles and their clinical competencies as desired by the patients.

In addressing the research gaps and problems, this study seeks to explore the interactional practices between FoDUM third year dental students and their patients by analyzing the interactional features employed in their talk. The analysis of interactional practices is later supplemented with the discussion about their experiences *vis-a-vis* satisfaction and communicative challenges when engaging together.

### 1.2. Research Questions

The present study is guided by the following research questions:

1. What is the structural mapping of the students-patient engagement in UM's Student Dental Clinic?
2. How are the student-patient interactional practices/patterns when engaging in UM's Student Dental Clinic?
3. How do UM students and patients view their previous engagements in relation to their sense of satisfaction and communicative challenges?

The first question that investigates the structure of the accessible data type incorporates the method proposed by Sarangi's (2010) Activity Analysis on structural mapping. The second question addresses the participants' interactional practices during the entire engagement by implementing discourse analytical approaches (see Section 3.3). Lastly, the third research question uses a thematic analysis to discuss the students' and their patient' experiences relating to the satisfaction and communicative challenges with their engagement.

## 1.3. Significances of Study

This study contributes towards understanding the challenges of the dynamic and hybrid nature of dental engagements as experienced by novice dental students when dealing with their patients. By doing this, it is hoped that it will increase awareness among dental educators and students, that will lead towards improvements in dental service care, especially for the Faculty of Dentistry, UM.

## 1.4. Dentistry as Health Profession in Malaysia: A Brief Background

Like other medical related fields, dentistry is a profession where practitioners aim to attending to patients' needs and wants. Dentists are concerned about all kinds of oral diseases and conditions related to their patients' dental care. Their role is also to monitor the development of their patients' teeth and jaw besides diagnosing and handling the oral health problems relating to a patient's gum, teeth and other parts of the mouth. Surgical procedures on patients' soft tissues, bone and teeth of the oral cavity must be performed when the need arises. Dentist need to execute these tasks properly in order to prevent any of the encountered oral problems to recur. If dentists do not address these issues properly, patients can experience increased inflammation in mouth for instance, and inevitably cascade into other health problems (Sutton, 2008). Because of this, dentists have to be aware of their patients' oral health and psychosocial background histories through communication (Freeman, 1999).

The dental healthcare system in Malaysia is specialized and numerous roles are designated to take care of various services. There are generalists and specialist dentists, and they are supported by dental auxiliaries (dental nurses, dental technicians, dental surgery assistants). Individuals who opt for a career in becoming a dentist have to undergo a five-year degree program in a recognized institution before being awarded a Bachelor of Dental Surgery (BDS). Upon completion, they must serve a compulsory service for the government under the Ministry of Health as a dental officer. Registered dentists may later choose to become specialized, and they may opt to continue working for the government or set their own private dental practice registered under the Malaysian Dental Council, or even work with the armed forces. Others may become lecturers or dental researchers (Malaysian Dental Council, 2012; Ministry of Health Malaysia, 2013).

## 1.5. Bachelor of Dental Surgery in UM: A Brief Background

The undergraduate dentistry program in FoDUM is a five-year programme, encompassing of two learning phases. The students attend classes in the first phase in Years 1 and 2. In this phase, they acquire and develop dental and other medical-related knowledge, in collaboration with the Faculty of Medicine in the University of Malaya. The mandatory clinical practice begins in Year 3 until Year 5, with supervision, to hone their clinical and interactional skills with real patients in the clinic. The holistic approaches have been devised in line with recent implementation of the undergraduate dental education across the world, where active learning pedagogy is set up to produce professional dentists (UM Bachelor of Dental Surgery, n.d.).

There are communication skills courses embedded in the five-year program. Identical to other compulsory courses, the communication handbooks are correspondingly documented with relevant course objectives, learning outcomes and particular communication syllabuses for each week. Nor Azlida et al. (2011, p.1617) mention that compared to Universiti Kebangsaan Malaysia (UKM), communication skills course in UM is far broader and more extensive. It ranges from hours of didactic lectures, interviews with patients, role-plays with simulating patients in gearing towards enhancing the students' communicative abilities. They also present the subjects that are covered under this course per year, as follows:

Year 1: A three-session problem based learning on effective communication

Year 2: A one-hour didactic lecture on dentist-patient relationship

Year 3: Role-play, a video presentation, interview with real patients and case presentation

Year 4: A home interview and presentation

Year 5: A one-hour lecture on communication and interpersonal relationship

However, the present study shows that the students are still battling with communicative challenges while undertaking clinical practice with actual patients (see Chapter 5).

The clinical sessions in UM's dental polyclinic are scheduled in the morning and/or afternoon daily. There are three different polyclinics and each is labelled as Polyclinic A, B and C for year 3, 4 and 5 dental students respectively. The research site for this study was in the Polyclinic A, where the participants were recruited. A pair of students involving an **operator** and an **assistant** attends to a patient in their personal cubicle. Below are the images as seen at the waiting area of Polyclinic A (Figure 2.1) and the close-up of personal cubicle (Figure 2.2) depicting the operatory-environment in which dental students and patients engage with one another:

Figure 2.1: Waiting area outside of Polyclinic A; Figure 2.2: Personal cubicle where students-patient engage with one another

Similar to other dental clinical practice, the patient's appointment slot in FoDUM is also set earlier from the visit date. The students regularly keep in touch with the patients to ensure that they will be attending on the scheduled date, otherwise it will disrupt the schedule. Patients who do not attend for three consecutive times will be removed from the appointment list and will be replaced by other patients.

There are different dental practices operating per day. The present study looks at the General Clinical Practice session – 'Basic Examination and Diagnosis' (Basic 'EnD'), where interactions are significant. The duration for a clinical session is 3 hours but the patient's dismissal also depends on certain inevitable factors. However, the basic 'EnD' session, which comprises of Parts 1 and 2 would normally finish in not less than an hour. In Part 1, a returning or new patient undergoes the history-taking procedure until he/she is given a verification of oral examination by the students' attending lecturer. In Part 2, the students would enlighten their patient on how to properly taking care of their teeth. However, this study focuses with Part 1.

The next chapter provides a review of relevant literature of previous research.

# CHAPTER 2: LITERATURE REVIEW

## 2.1. Introduction

This chapter discusses relevant information concerning dental and medical doctor-patient interactions, as well as how one can examine these interactions from various conceptual and theoretical viewpoints. The information provided here aids in answering the research questions. The sections are organized as below:

- Defining communication-interaction (Section 2.2)
- Discourse analysis of dentist-patient engagements (Section 2.3)
- Interactional practices in the workplace: Task and relational talk (Section 2.4)
- Activity analysis: Structural mapping of an engagement (Section 2.5)
- Discourse analytical features in spoken discourse (Section 2.6)
- Satisfaction in healthcare setting (Section 2.7)
- General overview in patient engagement (Section 2.8)

## 2.2. Defining Communication-Interaction

The term communication/interaction is difficult to define (Littlejohn & Foss, 2008). However, this study considers the definition of communication-interaction from a few angles including the definition from dictionary to the definitions proposed by a few scholars. A number of online dictionaries define communication and interaction almost correspondingly (Merriam-Webster, Oxford Dictionaries, Cambridge Dictionaries, as of (2016)): a reciprocal process of transmitting, conveying, exchanging of ideas, thoughts, emotions and/or information between interlocutors by means of employing a range number of lexical items that can be put forth into innumerable grammatical structures and styles in producing sequence of utterances (*discourse* from linguistics perspective)

towards attaining anticipated goals apart from contributing to be valuable members in their communities. This conception is thoroughly defined in a wider scope:

> *Communication is essentially about the transfer of information between people ... As such, communication can be viewed as a professional practice where appropriate rules and tools can be applied in order enhance [sic] the utility of the information communicated, as much as it can a social process of interaction between people*"
>
> (Dainty, Moore, & Murray, 2006, pp. 5-6)

Corcoran (2007) views communication-interaction in healthcare as a transactional process to impart health promotion work, which "involves a deep understanding of the patient" (Mathew et.al, 2015, p.8). From all the definitions given, communication and interaction can be perceived similarly: it is an activity of encoding and decoding of information between humans to achieve diverse transactional/task and relational goals in life.

Literature on doctor-patient communication-interaction have widely pointed out that effective and professional communication-interaction is a central component in healthcare setting that also influences multiple patient's outcomes especially in a positive manner (Roter, 1983; Stewart et. al, 1995; Arora, 2003; Shigli & Awinashe, 2010; Purtilo, Haddad & Doherty, 2014). Breakdown of communication happens when patients lack comprehension to what was said to them by attending doctors. This situation might put them at risk, and more importantly impair their ability to achieve health goals due to poor delivery of information (DiMatteo, 1998; Ha & Longnecker, 2010; Shigli & Awinashe, 2010).

The following sections discuss about 'discourse' or 'communication-interaction' in its layman terms which is also one of the main theoretical approaches utilized in the present study. These sections are followed with a section that discusses on the specific key concepts of interaction that are central in the workplace setting which are task talk and relational talk.

## 2.3. Discourse Analysis of Dentist-Patient Engagement

> *"Discourse analysis focuses on the jointly constructed process of interaction as it pays attention to the multifunctional, context-specific nature of language use"*
>
> (Finlay & Sarangi, 2006)

As the quote above shows, Discourse Analysis (DA) is a qualitative method that generally focuses on language use – it is "the study of social life, understood through analysis of language in its widest sense including face-to-face talk" (Potter & Wetherell, 1987; Shaw & Bailey, 2009, p.2). Encompassing broad distinct theories, this field offers rigorous methods into looking at written and spoken language in use (Traynor, 2006). Hence, this implies that DA helps inspecting the strategies and approaches people use when interacting. Shaw and Bailey (2009) suggest DA as one of the effective linguistic methodological approaches in health profession as it allows scrutiny of various interactional patterns of an activity.

Scholars like Roberts and Sarangi (2005) further posit that this approach focuses closely on the micro level of interactions and how the interactional goals are attained by actions, decisions and negotiations made by the speakers through speech. In both the dental and medical settings, DA has been utilized by the researchers as a tool to discover

the structure and interactions between doctor and patient, to inspect their interactional patterns that are connected to collaboration during team briefings and many more (Wears & Perry, 2010 as cited in Gundrosen et al., 2016). Additionally, transcript is a conclusive element in DA that assists the researchers into inspecting and capturing the interactional dynamics that are not apparent through listening and observing.

The term 'discourse' however is ambiguous and cannot be pinned down into one meaning as different scholars from different disciplines hold different idea to what discourse is (Mills, 2004). Taking Foucalt's (1972, p.6) stance as cited in Mills (2004), 'discourse' as an interdisciplinary activity established in sociolinguistics, anthropology, computational linguistics, psycholinguistics and applied linguistics is all stretches of language, texts or **conversations** which carry meanings and have some effects to the real world. In relation to this study, the discourse of dentist-patient engagement - as a communicative system - includes the situation where the professionals need to solve the client's problems. Hence, this accentuates that the two-way process of verbal and non-verbal cues/communication between these agents is to serve the basis to overcome such issues (Hymes, 1972; Brown & Yules, 1986; McCarthy, 1993; Freeman, 1999; Sarangi, 2004; Gee, 2008; Mahrous & Hifnawy, 2012).

Freeman (1999) explicates that both types of communication in which either party will take turn to speak in providing accounts pertaining to his/her problems or in giving clarifications or probing answers (verbal) to questions and the other scenario for example, in which one agent watches and listens to the other agent attentively (non-verbal) determine the end results of the clinical engagement. Despite the previously mentioned acts, some studies reveal that the doctors' concern has been about the efficiency of their communication skills and how far their patients understand the clarification and information conveyed to them (Ammerman et al., 1992; Ong et al., 1995).

Glynn, Taylor & van Every (2002) claim that language as constituting social practices is a central feature of discourse studies. Additionally, such studies allow wide investigations into hidden linguistic features lie in talk that are not readily explicit to everyone (Zhang, 2010), simultaneously permits for interactional patterns documentation and improvement in a specific professional setting. The next section explains the hidden and substantial types of talk underlying the interactional practices in workplace engagements.

## 2.4. Interactional Practices in the Workplace: Task and Relational Talk

A string of interaction in the workplace holds different features and attributes reliant to particular conventions practiced by respective members in such an organization (Sarangi & Roberts, 1999; Heritage, 2005). It has been well-documented that institutional discourse as a sequence of workplace interactions constitutes two distinct components of talk: **task talk** (transactional talk in linguistics) and **relational talk** (relationship based conversation) in which the latter is understood to typically come into existence to assist the former type of talk (Lave & Wenger, 1991; Drew & Heritage, 1992; Hudak & Maynard, 2011).

These two talks often interconnect in distinctive ways and far from possible to be separated most especially in service provider-client interactions (Ragan & McCarthy, 2000). In clinical contexts, these variants of talk are interwoven in meeting patients' needs. Relational talk may appear anytime in the encounter and it is unpredictable and sometimes spontaneous (Valencia, 2009). Holmes and Stubbe (2003:89, as cited in Valencia 2009) also assert that "social talk [as relational talk] occurs at times and in spaces which are officially designated for non-work or social activities, activities when workers are free to develop and strengthen collegial relationships".

Participants by nature exchange their face needs when meeting, even during service transactions where they engage in both task and relational talk. Each serves its own goals that determines the outcomes of service encounter (Goffman, 1981; Goodwin, 2000). Maynard and Hudak (2008) quote Holmes (2000) in their study of small talk which states that relational talk "oils the social wheels of work talk". Although it is not a constitutive component during service encounters, its existence helps to formulate an interpersonal function – thus helps getting the interaction underway and overall embodied discourse to be concurrently successful (Brasdefer. 2015).

Although relational talk is often perceived trivial and less important in workplace discourse, it does not disregard the fact that the application of it together with task talk reflects and projects interpersonal expertise and competence in the professional setting (Holmes & Marra, 2004). Scholars who have done research on interactional dynamics within institutions such as Coupland (2000), Maynard and Hudak (2008) have pointed out discrepancies between these two talk and their characteristics are as follows:

Table 2.1.: Discrepancies between task talk and relational talk

| **Task Talk** | **Relational Talk** |
|---|---|
| Transactional | Interpersonal/Social |
| Instrumental | Relational |
| Goal-oriented | Not-goal oriented |
| Means-end rational | Value rational |

(Coupland & Homes, 2000; Maynard & Hudak,2008)

In healthcare research, task talk equates to *'the voice of medicine'* representing "technical interest" that serves healthcare goals while relational talk is *'the voice of the life-world'* that aims for interpersonal goals, creating relational climate and reducing anxieties like

small talk, laughter, joking episodes (Mishler, 1984 cited in Sarangi & Roberts, 1999; Coupland, 2003, p.17; Kerbrat-Orecchioni & Traverso, 2004).

The previous studies claim that patients' needs include the implementation of both talk (Stewart, 2005). Thus, both talks representing the relational goals of meeting should not be treated as dichotomous (Witczak-Plisiecka, 2013). Such practice during service encounters helps the healthcare institution to combat issues of noncompliance, dental complications, and litigations. This also correlates with the idea by clinical scholars who propose that researching these two facets of talk can help provide suggestions to improve clinical communication (Ben-Sira, 1980; Bensing, 1991; Ong et.al, 1995.; McCarthy et. al, 2006; Schiffrin, Tannen & Hamilton, 2008). Therefore, this study also sheds light on discussing the components of talking-type by associating them with relevant phases in a structure of engagement involved. Hence, the following section briefly explains about another sub-approach used in this study to answer RQ1 - that is to discover the structure of the present dental engagements.

## 2.5. Sarangi's Activity Analysis

Sarangi's (2010) 'Activity Analysis' (AA) framework which premises on Levinson's notion of Activity type (Levinson, 1979, Sarangi, 2000) is one of the many perspectives residing under 'Discourse Analysis'. It includes "an overall mapping of structural, interactional and thematic trajectories of a given encounter as a way of identifying activity-specific coherence and incoherence as well as critical moments for further detailed analysis" (Sarangi, 2000, 2005, p.178). Emphasizing on both focal and analytical themes, this framework allows inspection at the micro-level and macro-level of interaction against the setting of professional contexts and realities (Sarangi, 2005). Over the years, AA approach has been used with particular professional domain of medical

setting (Sarangi, 2000, 2004; Sarangi & Roberts, 2005). An instance is where AA as an approach offers interactional and thematic mapping as tools to help analysts identify the 'good' and 'bad' interactional trajectories of the oral medical examination context for their further scrutiny. There is also an ongoing study that looks at how the patterns of interaction in the prescription and non-prescription of antibiotics (Sarangi, 2006).

Using AA, Sarangi also discovers noticeable differences of interactional patterns between the professionals and clients in the domain of genetic counselling and other counselling or therapeutic settings. Unlike in other typical counselling settings, he finds that genetic professionals spend more time explaining the consequences, risks, moral issues, results. In other settings, the norm is for the client to take the center stage in troubles-telling. Sarangi's AA assists in identifying the interactional types by (also) connecting the micro and macro level of the work-related activity under inspection in institutional encounters – or structured activities organised around tasks (Drew & Heritage, 1992, p. 178).

When applying AA in institutional encounters, we can examine structures where joined social actions interplay with modes of task and relational talk between the active agents that help them achieve their aims of meeting (Agar, 1985; Drew & Heritage, 1992). Sarangi's (2010) 'Activity Analysis' that lies under discourse study emphasizes the importance of the multi-functional, context specific nature of language in both spoken and written contexts consists a framework on structural mapping that permits an identification of the relevant phases constituting an engagement – the mapping of entire engagement. For instance, Sarangi (2010) identifies the following to be constitutive of a primary care engagement (opening – symptom – treatment – symptom – closing). However, it does not have to be rigid and sequential. Chapter 4 explicates the findings of structure or phase found in the data to better understand the "dynamic and hybrid nature

of a given activity type" when discerning the interactional practices involved. The next section further discusses the other relevant discourse analytical features used to answer RQ2.

## 2.6. The Discourse Analytical Features of the Interactional Practices

The interactional practices using the following discourse analytical features are scrutinized on different phases and they are determined beforehand from the tool offered in Activity Analysis (as elaborated in the previous section). Comprehensively, this study investigates the participants' interactional practices in light of:

- Code-switching and Variant Codes (Section 2.6.1)
- Address forms and Pronouns (Section 2.6.2)
- Managing Talk: Turn-taking, Overlapping, Interruptions (Section 2.6.3)
- Question-Answer-Type During Data Gathering (Section 2.6.4)
- Speech Acts (Section 2.6.5)

These features were incorporated because the preliminary analysis (and by linking it with relevant phases) showed two prototypical patterns exhibited by different patients in a multilingual setting that influence their social acts and the outcomes of an engagement. One prototypical pattern is where the students need to deal with an active patient (talkative patient) and the other is by having to deal with the passive patient (non-talkative patient). The term 'active' or 'passive' is used in the study following the observation and analysis to how participative the patient is during the dental/clinical engagement.

### 2.6.1. Code-switching and Variant Codes

According to Saville-Troike (2003), Wardaugh (2010) and Guzman (2016), 'code' refers to the varieties of a same language or merely the different languages used by interlocutors on any given occasion. Code-switching as an instance, is the alternation of languages, the code-changing within one sentence or a single speech event (Saville-Troike, 2003; Myers-Scotton, 2005; Siregar, Bahri & Sanjaya, 2014; Novoa, 2015). In Malaysia, it is a common practice exhibited between individuals who are at least bilinguals from differing linguistic background of Malays, Indians and Chinese and other ethnic groups. This is in pursuit for solidarity, familiarity, alleviation to face-threatening situation or for good communication when their dominant language is alternately switched to another language or codes within the course of interaction (David et. al, 2009.; Hall & Nilep, 2015; Green & Wei, 2016). Additionally, the varieties of patterns or speech style or "accent" may remarkably exist across different ethnic groups that are arisen from the influence of the ethnic languages (Saville-Troike, 2003).

Code-switching that is broadly used in both informal and formal setting acts as one of the accommodative strategies used between interlocutors when interacting with one another (Schmied, 1991; David et.al, 2009). In relation to this study that takes the multilingual context, the aforementioned assertion is supported by Chu (2005) who also claims that doctor-patient interaction involves code-switching in accommodating to each other's language or choice of code when interacting. For the doctors, the reasons to accommodate are to show respect, politeness, a code to reduce anxiety and fear as well as in pursuit to enhancing close doctor-patient relationship.

Faller et al. (2015) in their study on pharmacist-patient talk claim that code-switching as a language pattern is an effective tool of interaction with the patients who are proficient in English language. They further add that this strategy aids in establishing

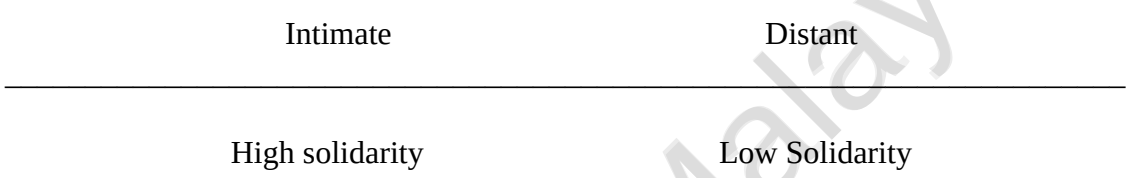
a patient-centered care during the deliverance of professional guidance and medication. The mixture of either Malay, Chinese or Tamil language which is the act of code-switching with English language is added depending on the patient's ethnicity. Nevertheless, the pharmacists' linguistic and social backgrounds are not specified in their short online academic literature when concern should also be directed at their language proficiency level, as those factors might influence patients' understanding. Malay language is excluded from discussion considering its role as a national, official language and a primary language in Malaysia – a language to national unity. Justly, there should not be serious issues arise when the speakers interacting in Malay language (Asmah, 1987; Jariah Mohd Jan, 2003; David et. al, 2009). Section 4.2 shows the analysis of code-switching and other variant codes enacted by the students and patient when doing either task or relational talk or both.

### 2.6.2. Address forms and Pronouns

Johnstone (2008) states that one of the ways in which the discourse roles, social distance and age of speakers can be indexed is through the use of address forms and pronouns (e.g. "you" or "*awak, kau*" in its Malay equivalent). According to Hofstede (1984), Malaysia is a hierarchical society in which politeness is remarkably observed and its citizens put high value on power and social distance, for example in an attempt to minimize conflicts. Hence, the use of apt address forms, honorifics or titles when interacting within this multilingual setting is one of the significant elements that helps differentiating people with distinct role relationship and simultaneously in showing respect by acknowledging one's social position (Kuang, Lau, David & Ang, 2011 as cited in Gan, David & Dumanig, 2015).

The various address forms that are available in many languages claim speakers' social distance of closeness or distance in relationships (Brown & Ford, 1964). Holmes' (1995) social distance diagram illustrates that the intimate use of address forms influences high solidarity while the use of distant address forms contributes to low solidarity between speakers (Figure 3.1). However, the use of intimate and distant address forms in relation to politeness differ across cultures.

Figure 3.1: Social Distance Diagram




In the Asian context for instance, Baron (2007) observes that even though individuals do not share blood relationship, they use address forms or local kinship terms to express politeness and intimacy. For example, the use of a second pronoun as in-group marker such as "brother/*abang*, sister/*kakak*" or "uncle/*pakcik* and aunty/*makcik*" is used for a male or female individual who is older than the speaker.

Interestingly, this is not the case with people in English speaking-countries when intimacy is sought. They do this using first names regardless of social roles and age disparity between the speakers involved (Gan, David & Dumanig, 2015). Above all, it is also suggested that the speakers decide on the selection of linguistic form for the success during the course of interaction – they address each other according "to the relation that governs the speaker and addressee" (Brown & Ford, 2003 as cited in Gan, David & Dumanig, 2015, p.53). While it is not an analysis highlight in this research, it is worthwhile noting that address forms and politeness are strongly associated together. Politeness, as explained by Watts (2003, p.9), is not an innate attribute or something that

people are born with, but rather is cogitated as a set of skills that individuals have to learn and acquire.

### 2.6.3. Managing Talk: Turn-taking, Latching, Overlapping and Interruptions

Sacks, Schegloff and Jefferson (1974) claim that organized 'turns' unit makes up the whole interaction in which normatively one speaker speaks at a time while others listen apart, and it involves a recurrence of speaker-change. Specifically, they posit that organized 'turns' unit makes up the whole interaction and accomplishes activities. The techniques of turn allocation which is the basis of interactional investigation are as follows:

- One speaker speaks at a time, notwithstanding the fact that a simultaneous speech may also be possible; and

Recurrence of speaker change – The floor is persistently negotiated and renegotiated. The floor is not specific for any of the speakers involved. One may ponder on how does this management of negotiation help in achieving an intended outcome of the whole participants' engagement. For each of turns, there is a set of rules called 'turn transition relevance place' that determines who should occupy the next turn (Boxer, 2002; Lerner, 2004; Mazeland, 2006) and these rules are condensed as below:

i. Current speaker selects next speaker
ii. Next speaker does the self-selecting or failing this
iii. Current speaker continues

However, the patterns of turns may vary depending on different genres (debates, meetings, court hearing) and it is of utmost significance to note that culture, audience and

purpose of interaction influence the procedures and the rules of turn-taking. Instances are how interlocutors passage to or leave the interaction, 'dictate' for longer turns, and how they refuse to establish a turn (by occupying the floor) without being regarded as discourteous and the like. In short, longer or shorter 'turns' pattern is influenced by various social factors (Ghilzai, 2015).

Besides latching that involves a tightly timed pattern of interaction in which participants' turns consist no gaps (Sacks, Schegloff and Jefferson, 1974), the reality of interaction also reveals about interlocutors who "talk over one another" indicating the existence of overlapping in interaction (Sidnell, 2012). Yet, not all overlapping speeches are instances of interruptions (Cerny, 2010). For instance, James-Clarke (1993) claims that 'backchannels' often overlap in an attempt to signal continuation, support, understanding, but they do not indicate any occurrences of interruption or disrupt the present topic under discussion (Goldberg, 1990). As it would be shown, the analysis of management of talk in Chapter 4 provides insights into how different students-patient manage their talk with each other and how this may influence their satisfaction with the whole engagement.

### 2.6.4. Question-Answer-Type during History-Taking

Boyd and Heritage (2006) propose three typical features or basic dimensions during history-taking that can distinguish how participants conduct accords in the creation of social acts. First, a patient may opt to engage or decline in the '**topical agendas'** set by the doctor, through the establishment of questions by responding or the opposite (resisting/ rejecting). Comprehensively, the formation of topical agendas lead into the existence of what is termed as '**action agendas'** in which the patients perform other actions apart from what have been mentioned above - they may justify, explain, clarify to the questions posed.

History-taking largely corresponds with the act of interrogating by the healthcare provider through questions. One can discover in various patient's answering styles to the 'preference' questioning type posed by the doctor especially when there is a normatively expected type of answering; 'alignment' and 'disalignment'. Following Sacks (2010), the same authors in their work mention that for example, the vocalization of a brief 'yes/no' without any significant delay and in a linear fashion is the preferred or expected type of answer to close-ended questions and vice versa. The following table illustrates the mentioned explanations.

Table 2.2: Question-Answer-Type during history-taking

| **Doctor questions** | **Patient responses** |
|---|---|
| Set agendas:<br>i. Topical agendas<br>ii. Action agendas | Engage/Decline to engage<br>i. Topical agendas<br>ii. Action agendas |
| Incorporate preferences | Align/Disalign with preferences |
| Embody presuppositions | Confirm/Disconfirm presuppositions |

The break of this norm through language, however, can tell or presuppose a person's attitude or personality. It also influences the outcome of the participants' engagement. In relation to this study, a patient who breaks the norm or practice of the preferred-answer-type may influence the outcome of the engagement including extending the time allotment, creating dissatisfaction amongst the other parties involved and others (Boyd & Heritage, 2006).

The analysis on question-answer-type (focusing on task talk) during history-taking allows for the documentation of how different participants in this multilingual setting follow or flout these three basic dimensions of practices discussed.

Simultaneously, it can help reveal reasons to the participants' sense of satisfaction or dissatisfaction with the engagement.

### 2.6.5. Speech Acts

Speech acts which may be direct or indirect, are generally defined as "actions performed via utterances" (Yule, 1996, p. 47). A direct act happens when there is a direct relationship between the structure of an utterance with its function and vice versa for indirect act. Some examples of speech acts include promise, request, invitation, compliment and others.

Clealand et al. (2013) in their work state that doctors engage in several ways of communicating with the patients. For example, during history-taking, the speech acts of questioning and answering are mainly found in soliciting and gathering relevant data for diagnosis-making. They further mention that during physical examinations, directing is used by doctors to instruct patients to follow their order, questioning is to query the patient's feelings, sensations concomitant to the examination, and stating/ informing to explain what they see, feel while performing the examination.

In this research, the speech acts analysis examines the communicative activities found in task talk – specifically during physical examination (Section 4.5.2) to discover and describe the available performative actions by the attending operators, when communication is claimed to be relatively minimal (Clealand et al., 2013). This analysis also allows an inspection on the students' professional roles while undertaking physical examination – as speech acts and professional roles are associated with each other (Stubbe, 1983).

## 2.7. Satisfaction in Healthcare Setting

Satisfaction is defined as "a person's feeling of pleasure or disappointment resulting from comparing a product's perceived performance or outcome, in relation to his or her expectations" (Kotler, 2003, p. 61). In connection with the present study, satisfaction is the outcome of healthcare process that successfully answers patients' needs and their expectations of the clinical encounter are adequately met (Sanders, Spencer & Stewart, 2005).

Simpson et al. (1991) postulate that the numbers of complaints of dissatisfaction in many countries with the healthcare profession have often covered the issue of deficiencies in clinical interaction between the doctors and their patients. The authors further state that the doctors' language is unclear with full of jargon and terminologies that eventually leads to misperceiving the amount of clarifications that the patients want. Such issues influence the patients' positive ultimate outcome that it minimizes their level of satisfaction with the engagement.

Alazri (2003) (as cited in Fong Ha, Longnecker & Anat, 2010) and Brennan et. al (2013) propose that patients would likely maintain their existing doctor-patient relationship if they experience good outcomes and processes in which their autonomy is recognized and every single aspect is in their best interest from the previous care received. There are a number of factors that influence and determine patients' level of satisfaction. For example, the doctor's technical competency, doctor's manners during treatment, waiting times, clinical setup or equipment, and administrative efficiency (Holt & McHugh, 1997; Mahrous, Hifnawy, 2012; Lee, Wright & Semaan, 2013). A study done by Mahrous and Hifnawy (2012) illustrates that patients give high ratings of satisfaction when dentists provide an adequate explanation and clarification before, during and after interventions.

Above all, Bensing et al. (1991) also proposes that patients' need includes the following ***"the need to feel known and understood"*** - pointing to socio-emotional communication or "care-oriented interactions" in medical research (Desjarlais-deKlerk & Wallace, 2013) which is relatable to relational talk in linguistics. Thus, integrating relational or small talk is also one of the most highly valued factors for healthcare practitioners. This is because both task and relational talk (despite mentioned need in boldface) can help make their patients feel more at ease and comfortable during the encounter, thus coherently satisfying their overall communicative needs (Williams, Weinman, & Dale, 1998; Chang, Kyu Park & Soo Kim, 2013).

Relational talk helps flourish the ***therapeutic alliance*** between doctors and patients as it would result in helping these patients to improve their health outcomes and at the same time experiencing satisfaction (Bensing, 1991; Aruguette & Roberts, 2000; Desjarlais-deKlerk & Wallace, 2013; Waylen, Makoul & Albeyatti, 2015). Doctors would then experience fewer-related stress, reduced burnout, and greater job satisfaction in return for patients' satisfaction (Pitceathly & Maguire, 2003; Bredart, Bouleuc & Dolbeault, 2005).

## 2.8. General Overview of Patient Engagement

A number of structured assessment termed 'the medical history', 'past dental history which includes family and personal history', and 'drug history' that function to gain a comprehensive picture of patients' overall health conditions and problems should be thoroughly assessed in the field of dentistry. These assessments come after patients have presented main complaints about their dental problems and prior to submitting themselves to any type of physical examination or dental health care. By raising the aforementioned actualities, certain factors require attention during this phase of consultation. It is suggested that a well-taken history will often postulate better hints/clues

of a problem presentation than the physical examination itself (Chatten et al., 2013; Chipidza, Wallwork & Stern, 2015). This also serves a basis to a good rapport and trust between clinical student/dentist and patient. Chatten et al. (2013) propose several general guidelines for each healthcare practitioner irrespective novice or senior to initiate an effective consultation as follows:

| |
|---|
| **1. Introductory phase**<br>• Consider the background noises |
| **2. Establishing rapport**<br>• Smile and include ice-breaking session<br>• Introduce own self (e.g. third year dental student)<br>• Secure consent that the information acquired will be passed to doctor<br>• Be supportive, show interest and respect to patient<br>• Accept patient's views and feelings |
| **3. Gathering Information**<br>• Inform the time allocation<br>• Use close-ended questions when no specific information is needed<br>• Listen attentively, make eye-contact, summarize patient's utterances<br>• Provide explanations<br>• Use visual(s) while explaining<br>• Give time for patient to talk but manage it wisely<br>• Apply concise and understandable language<br>• Comprehend and explore their views, concerns, expectations, feelings |

**4. Physical examination**

- Alert patient about the processes and seek prior permission
- It is discouraged to continue with the treatment if patient seems to be in discomfort (have to adhere to patient's needs and concerns)
- Show tenderness and always enquire if they feel any pain

Styles of communication are the most important element here mainly for clinical students when interacting with patients. It is of utmost importance to be aware of what and how to say something. In relation to this study, the students at most times might have accidentally and unintentionally uttered medical or/and dental jargon while doing task-talk in the pursuit of task related goals. For instance, they might have asked questions or made dental statements to their patients when consultations with patients should be free from any use of jargon. This is also evident in the data when the interviewed students claim that (at times) they were unable to avoid the use of dental jargons with their patient due to the difficulty in translating it into layman term (Chapter 5).

This is also a common case with case presentations, where notes are full of jargon that students have been very familiar with (Chatten et al., 2013). However, if using a technical term is inevitable, the students then have to provide the meaning of such term and always check with their patients whether or not they understood (Farzadnia & Giles, 2015). As Nield-Gehrig (n.d.) posits, the primary function of effective communication in dental care setting is to reach a mutual understanding between participants involved.

Chatten et al. (2013) note that clinical students may refrain from asking their patient's feelings due to the feeling of embarrassment they may encounter. In addition, if the students are asked about some particular diagnosis that they are unable to meet with, they should remember about reiterating and acknowledging their patient that they are still

learning. They need to give notification that such queries and request for information will be passed to the respective doctor/dentist – further clarification will be given by a doctor/dentist. Bub (2004) and Kavanagh (2015) mention that other qualities apart from effective communication like patience, practice, concentration, empathetic are necessitated at this stage especially for the dental students who have just begun with their clinical practice with actual patients. This is crucial for a good history taking despite the ability to attend to both their and patient's needs simultaneously in attaining high ratings of satisfaction.

## 2.9. Summary of the Chapter

This chapter has explicated a review of relevant literature which enables a thorough understanding of possible theories and approaches that are used in this study, relating to the interaction in dental practices and ways to approach the research questions.

# CHAPTER 3: METHODOLOGY

## 3.1. Research Methods

This chapter comprises three fundamental sections constituting the methods used in this study. The first section discusses the selection, ethics clearance, and justifications for the selected data in a great detail. The second section discusses the methods and procedures of data sources and the third section discusses the methods of data analysis. The outlines of this chapter are as follows:

- The students and the patients (Section 3.2.)
- Methods and procedures of data collection (Section 3.3.)
- Approach to analysis (Section 3.4.)
- Transcription method (Section 3.5)

## 3.2. The Students and The Patients

The data used in this study include i) ethnographic observations of 10 natural audio and video recordings of different cases, where each engagement features two dental students and a patient in a cubicle, and ii) semi-structured interviews with the dental students and patients. These were collected at the Faculty of Dentistry, UM Students' Dental Clinic/Polyclinic. This section covers:

- Ethics approval/consideration (Section 3.2.1)
- Participants' background (Section 3.2.2)
- The dental students (Section 3.2.3)
- The patients (Section 3.2.4)

### 3.2.1. Ethics Approval/Consideration

The ethical approval for this study was sought twice. The ethical forms were first sent in December, 2015 to the Medical Ethics Committee, FoDUM. Following that, the primary researcher was informed approximately two and a half months later that the whole approval cannot be obtained from the Faculty of Dentistry for a particular objective that this study first intends to accomplish – improve the dental curriculum. In response to such circumstance, the existing ethics forms are amended accordingly based on the raised concerns. The present study is approved by the Medical Ethics Committee in March, 2016. An approval letter consented by nine Ethics Committee members. The Ethics Committee/IRB reference number is **(DF RD 1616/0051 (P))**.

Copies of the ethical forms and full ethical approvals from the Ethics Committee and relevant respondent information sheet can be found in Appendices A and B. All procedures strictly adhered to the ethical standards set out by the Medical Ethics Committee in FoDUM. There are two separate information sheets used in this study. One sheet is prepared for the students and another sheet is prepared for the patients. Relevant consent forms for all participants can be found in Appendices C and D respectively.

### 3.2.2. Participants' Background

The demographics of participants involved in this study are shown in the following Table 3.1, Table 3.2, and Table 3.3. More information on the patients' background are also illustrated in Table 3.4:

Table 3.1. Demographics of third-year multi-racial student-operators

| **Sex** | **Male** | | | **Female** | | |
|---|---|---|---|---|---|---|
| | **3** | | | **7** | | |
| **Ethnic Group** | **Chinese** | **Malay** | **Indian** | **Chinese** | **Malay** | **Indian** |
| | 1 | 2 | 0 | 2 | 5 | 0 |
| **Age** | **22** | | | | | |

Table 3.2. Demographics of third-year multi-racial student-assistants

| **Sex** | **Male** | | | **Female** | | |
|---|---|---|---|---|---|---|
| | **3** | | | **7** | | |
| **Ethnic Group** | **Chinese** | **Malay** | **Indian** | **Chinese** | **Malay** | **Indian** |
| | 2 | 1 | 0 | 3 | 4 | 0 |
| **Age** | **22** | | | | | |

Table 3.3. Demographics of multi-racial patients

| | **Male** | | | **Female** | | |
|---|---|---|---|---|---|---|
| | **5** | | | **5** | | |
| **Ethnic Group** | **Chinese** | **Malay** | **Indian** | **Chinese** | **Malay** | **Indian** |
| | 3 | 1 | 1 | 1 | 3 | 1 |
| **Age** | 30> | | | | | |

Table 3.4. Patient's background details

| **Patient** | **Ethnicity** | **Age** | **Gender** | **Occupation** | **Highest Education** | **First Language (L1) and Other Familiar Languages** | **New/ Returning Patient** |
|---|---|---|---|---|---|---|---|
| 1 | Chinese | 60 | Male | Businessman | Cambridge examination after high school | **Hokkien (L1)** English, Malay, Mandarin and other Chinese dialects | New Patient |
| 2 | Indian | 37 | Female | Housewife | Primary school | **Tamil (L1)** Malay, English (not fully proficient, and only understand simple English) | New Patient |
| 3 | Chinese | 36 | Female | Unidentified | Unidentified | **Mandarin (L1)** Malay is better than English | New Patient |
| 4 | Chinese | 61 | Male | Retired | Secondary school | **English (L1)** Malay and a few of Chinese dialects | New Patient |
| 5 | Indian (Sikh) | 79 | Male | Retired | Senior Cambridge | **Punjabi (L1)** English Malay | New Patient |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6 | Malay | 33 | Female | Medical Doctor | Ongoing Postgrad UM Student | **Malay (L1)** English | Returning Patient |
| 7 | Malay | 49 | Female | House-wife | SPM | **Malay only (L1)** | Returning Patient |
| 8 | Chinese | 51 | Male | General Manager | Bachelor of Chemical Engineering in UM | **Mandarin (L1)** English, Malay, A few of other Chinese dialects | Returning Patient |
| 9 | Malay | 30 | Female | Admin-istration | Diploma | **Malay (L1)** English | Returning Patient |
| 10 | Malay | 57 | Male | Retired | SPM | **Malay (L1)** English | New Patient |

Table 3.1 and Table 3.2 illustrate the students' details on their sex, ethnic group and age. From the two tables, the student-operators and the student-assistants are in the same age group (22 years old). The students' race are Malay and Chinese. Similarly, Table 3.3 shows the patients' details on the same mentioned criteria of their sex, ethnic group and age. Malay, Chinese and Indian patients participated in this study. Their age group ranges from 30 years old to 79 years old.

Meanwhile, Table 3.4 charts each patient's background details in terms of their ethnicity, age, gender, occupation, highest occupation, languages used (and known), and whether each is new or a returning patient. From the table, three participants have retired, one is unidentified while the others have occupation at the moment that the study is carried out.

### 3.2.3. The Dental Students

All third-year dental students are given prior notice about the present study by their students' representative. The representative is first recruited and a thorough briefing about the study is given by the researcher and her supervisor three days prior to the actual weeks of data collection. The researcher is informed by the students' representative that the dental students who are working in the clinic are mindful of the researcher's presence around the clinic. Dental students who are recruited as participants in the study are those who are undertaking basic clinical practice of 'Examination and Diagnosis' (EnD).

Two dental students are involved in all types of dental practices. The primary dental student functions as the dental student-operator while the other one is the dental student-assistant. The student-operator plays a major role in achieving the objectives of the engagement during the clinical session as s/he takes the center stage in interviewing, diagnosing and clinically treating the attending patient.

All eligible students (those who conducted *Basic EnD* of the day) for this study are very cooperative and they give consent to be audio-recorded, video-recorded and interviewed. None withdrew either at any stages during the recordings and interview sessions. Altogether, a total of 18 dental students (aged 22 years old) including the student-operators and student-assistants participated in the study. All students are at least bilinguals that they speak their mother tongue of either Malay, Chinese as their first language and English as their second language. There is no gender differences in terms of selecting the dental students as the connection between language and gender are not one of the objectives in the study. For the anonymity of the dental students as participants, they are coded as S.O 1/2/3/4/5/6/7/8/9/10 (student-operator) and S.A 1/2/3/4/5/6/7/8/9/10 (student-assistant) in this study.

### 3.2.4. The Patients

The consenting dental patients are all adults between 30 and 60 years old. The patients are a mixture of active and passive patients. From an interview conducted with the students who are the participants in this study, it is found that the usual patients who come to the clinic are mostly those individuals in the age range of 30-70 years old. The patients arrive to the clinic at the scheduled time set by the faculty. They are reminded by their attending dentists for their appointment via phone calls and text messages.

The researcher is clueless about the individuals who will be the students' patients until the day of appointment itself. Additionally, the researcher also has no knowledge about the patients' attendance whether it is the first visit or a follow-up on previous visits. The patients are recruited on the same day and this is subsequent to obtaining consent from the students. All patients approached have agreed to fully cooperate in this study. None refused and all participants consented to be audio-recorded, video-recorded and to participate in the semi-structured interview.

A briefing about the present study is given before the patients proceeded with the clinical treatment. The patients come from various ethnic groups of Malay, Chinese and Indian. There are five males and five females who consent to participate in this study. Some of the patients are employed and some also run their own businesses. The patients are coded and abbreviated as 'P' 1/2/3/4/5/6/7/8/9/10 (patient) in the study - for their anonymity.

### 3.3. Methods and Procedures of Data Collection

Informed consent from all participants was obtained before the data collection. A class representative of third year students is first recruited and briefed about the intended study. He is asked to notify the remaining third year students in regard to the researcher's presence for the approaching weeks to come. A list of schedule together with the names of the attending supervisors also is obtained from the class representative as well as from a staff in the faculty.

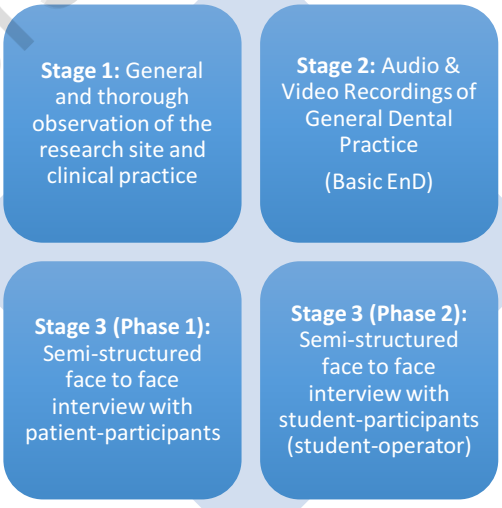
The researcher's supervisor from the Faculty of Dentistry and other research collaborators from the same faculty notifies the daily attending supervisors/ doctors 'about the purpose of this study so that they are aware of the researcher's attendance. The researcher gets positive feedback and consent from all parties involved. All participants approved the researcher's intention and signed the given consent form.

Recordings are made when the possible data are available for each day when the students perform Basic EnD. This is because Basic EnD may or may not run every day. All in all, the data collection period ranges for four weeks. The researcher obtains only one recording of session per day – ten recordings in total as the data samples. The video-recording spans in between 1 hour and more in length. Some of the sessions stop at Part 1 (first-half of the completed session) that they cannot proceed to Part 2 (following part) due to the advice given by the attending doctor/supervisor. The audio-recordings and video-recordings collected for this study are a mixture of either Part 1 or completed session (Part 1 & 2) (See Section 1.5). Though three students mention to the researcher about having completed the whole session, the data only capture Part 1. This may be due to technical failures or the students forgot to switch on the recording devices, as students need to pause the recording tools/instruments when the attending lecturer (doctor) is present inside the cubicle. Thus, the data are accessible from Part 1 of the dental session only.

The data are first collected on April 21st[st], 2016 onwards – one week after the approval letter is given. The primary researcher is able to collect audio and video-recording of interaction for four days per week during the first week due, as the students are nearing the end of semester. In addition, this study has long been delayed due to the ethical procedures and for this particular reason too, the researcher and all parties involved agree to proceed with the data collection right after a letter of approval is handed to us.

However, the researcher is informed by the class representative on the second week that the dental practice of Basic EnD is not available every day. Hence, only three sessions of recordings are obtained on that particular second week. Two sessions are managed to be recorded on the third week and only one session of recording is obtained on the fourth week. As mentioned in 3.2, there are altogether 10 videos of cases obtained within the four-week period. The stages of data collection are as illustrated in the boxes below:

Figure 4.1. Stages of data collection procedures




The patients recruited are also a mixture of new and returning patients. They are first approached and interviewed before they leave the clinic. The patients are cooperative that

they also consent to participate for the interview session. This makes this study easier in terms of gaining patients' opinions as they may not visit the clinic anytime soon after their treatment and will be difficult to contact again. All participants are told that they can withdraw from the research at any time.

For the video recordings, the instrument (of video camera being attached with a tripod) is altered/positioned differently in the successive days in order to ensure the minimization of observer's paradox that may change participants' behavior and possibly the way they interact with one another. It is nevertheless, a challenge for the researcher to best place the video camera since the cubicle is small and packed. Nevertheless, it is still placed at the right angle that best captures respondents' non-verbal communication in order to understand the context of the engagements. The researcher placed the camera on top of a small table she brings for the first four consultations.

However, after realizing that the position of camera blocks participants' facial expressions, the researcher places the camera on top of a dental cabinet/countertop on the following day to best capture all the participants involved. It is through the primary researcher's observation that the participants (of both dental students and patients) seem to not alter their action(s) even though they are conscious of being the subjects under investigation. The recordings of the sessions are also found not interfering the dental work run by the student-operator and student-assistant over the course of time as everything is appeared to be natural and smooth.

The students are aware of the instruments presence at first, but they gradually forget about the instruments' existence as they go through the course – as claimed by the students themselves. The second instrument, which is an audio recorder is placed on a small dental-cabinet. Its position is near to the participants (to overcome the background noise that appears) and this is important to better listen to their interaction and to preserve the degree of validity and reliability of the recorded interaction as well as to ensure that

they are constantly to be ethically justifiable. However, it is found that the participants' interactions are better captured with *Go-Pro* camera as opposed to the *Philips* audio-recorder. This limitation pertains to the unexpected outcome for each instrument and this is also out of researcher's control (images of instruments used for both different forms of recordings are shown and briefly described below in Figure 4.2).

Collected data are highly taken care of - the precautions are confidential that the participants involved will not be heard and viewed by multiple people for other non-research purposes. Additionally, the subject's face will not be revealed (by means of censoring) if by any chance that the extraction of videos will have to be disclosed for future presentation purposes. This is crucial in maintaining their privacy and anonymity Below are the research instruments/recording tools used in this study.

Figure 4.2: Go-Pro Hero 3 and Philips Voice Tracer digital recorder VTR5000 were used for the audio video-recordings


This Go-Pro Hero is connected and paired with researcher's personal cellphone (iPhone 5) for the purpose of capturing the students-patient engagement. Such implementation has made it easier for the researcher and students to monitor and control the video-recording during the dental engagement. The following coding in Table 3.5 reveal information for each engagement between the students and their patient to better understand **the context** of the dental engagements.

Table 3.5. Contextual engagement of participants

| ***Engagement*** | ***Role*** | ***Gender*** | ***Age*** | ***Race*** |
|---|---|---|---|---|
| ***1*** | *Student-operator* | *Female* | *22* | *Malay* |
| | *Student-assistant* | *Female* | *22* | *Malay* |
| | *Patient* | *Male* | *60* | *Chinese* |
| ***2*** | *Student-operator* | *Female* | *22* | *Chinese* |
| | *Student-assistant* | *Male* | *22* | *Chinese* |
| | *Patient* | *Female* | *37* | *Indian* |
| ***3*** | *Student-operator* | *Female* | *22* | *Malay* |
| | *Student-assistant* | *Female* | *22* | *Chinese* |
| | *Patient* | *Female* | *36* | *Chinese* |
| ***4*** | *Student-operator* | *Female* | *22* | *Malay* |
| | *Student-assistant* | *Female* | *22* | *Chinese* |
| | *Patient* | *Male* | *61* | *Chinese* |
| ***5*** | *Student-operator* | *Male* | *22* | *Chinese* |
| | *Student-assistant* | *Female* | *22* | *Malay* |
| | *Patient* | *Male* | *79* | *Indian (Sikh)* |
| ***6*** | *Student-operator* | *Female* | *22* | *Malay* |
| | *Student-assistant* | *Female* | *22* | *Malay* |
| | *Patient* | *Female* | *33* | *Malay* |
| ***7*** | *Student-operator* | *Male* | *22* | *Malay* |
| | *Student-assistant* | *Male* | *22* | *Malay* |
| | *Patient* | *Female* | *49* | *Malay* |
| ***8*** | *Student-operator* | *Female* | *22* | *Chinese* |
| | *Student-assistant* | *Female* | *22* | *Malay* |
| | *Patient* | *Male* | *51* | *Chinese* |
| ***9*** | *Student-operator* | *Male* | *22* | *Malay* |
| | *Student-assistant* | *Male* | *22* | *Chinese* |

| | | | | |
|---|---|---|---|---|
| | *Patient* | *Female* | *30* | *Malay* |
| ***10*** | *Student-operator* | *Female* | *22* | *Malay* |
| | *Student-assistant* | *Female* | *22* | *Chinese* |
| | *Patient* | *Male* | *37* | *Malay* |

Face-to-face semi-structured interviews were conducted with selected students (the operators) and the patients to gain understanding of their views, perspectives and accounts of an event related to their previous visit with one another. Identification of their expectations to understand their wants and needs are also collected – this can simultaneously help filling in the gap(s) and improving the quality of the future dental care. This semi-structured interview is done after the session is completed. Interview sessions are audiotaped independently for both of the operators and the patients.

For the student-operators, questions revolve around their clinical engagements in relation to professional communicative practices and patients' satisfaction. Meanwhile for the patients, questions focus around their satisfaction with regard to their experience with the visit, quality of care that is achieved through conversational exchanges (between the dental students and themselves) and expectations with the service/care they receive. The semi-structured interview questions can be found in Appendix H. The interview takes not more than 15 minutes and is conducted at the locations preferred by the participants, but within the clinical area in FoDUM. Overall, they agreed to be interviewed either at the waiting area outside of Polyclinic A or the waiting area outside Polyclinic C.

The patients are interviewed without the presence of their attending dental students and vice versa for the students. The allotted time for the interviews is different for the patients and students. This is to ensure that any responses made are not influenced by the presence of either the students or patients so that they can be free to provide responses. Accordingly, the responses can be deemed more reliable and valid. At the

beginning of the interview, participants are again briefed about the study and they are also given prior notice about how they can ask the researcher to skip to other questions if they feel uncomfortable with any of the questions posed. Some participants offer extensive opinions with regard to questions pointed to them. However, there are also a few patients who are in a rush that the researcher feels their opinions are not clearly elaborated. There is no element of coercion in terms of gaining feedback from participants.

Participants are also assured about how their privacy will be respected at all times and that the researcher will never disclose their identity to anyone/elsewhere outside the study. The transcribed interviews are revised and a thematic analysis is done. The patients are recruited immediately after they have finished with their clinical consultation with the dental students. Some of the operators are extremely busy that they miss the interview session on the day of recordings. Two out of ten patients do not consent to let the interview be recorded.

### 3.4. Approach to Analysis

For RQ1, Sarangi's (2010) framework of AA on structural mapping is embedded in the discourse study of the present dental engagement. This is crucial to gain an 'early insight' as this mapping provides a better exemplification and understanding of the entire phases / each phase that the participants have to undertake in Part 1 of EnD and Diagnosis. This inspection is also to see how the actions and tasks are organized in a present activity dental type before the textual manifestations/features in talk. The phases in which task and relational talk are done (and should be done) are also shown.

For RQ2, a discourse analysis approach of the students-patient talk is examined and documented to discover the kind of interactional practices deployed between the

active agents in the professional context and how this, may or may not influence the students and their patient satisfaction level with the engagement (which is further elucidated in Chapter 5). Figure 4.3 illustrates the approaches used in answering the first two research questions:

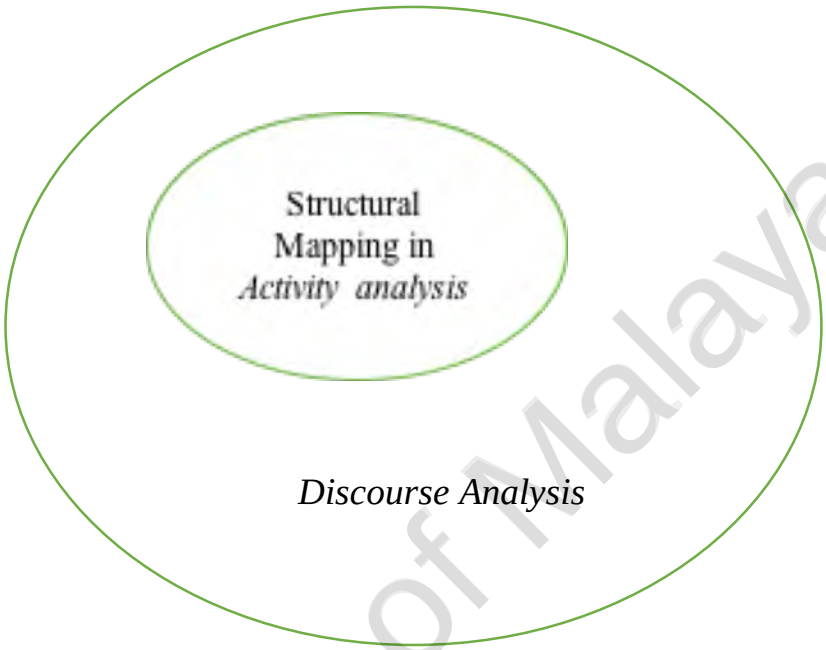



Figure 4.3. Framework of analysis

Explicitly for RQ2, the following are the analytical themes/theories injected as tools for the discourse study of the students-patient engagement:

- Choice of code and code-switching by Saville-Troike (2003), Wardaugh (2010) and Guzman (2016)
- Address forms, pronouns and politeness by Holmes (2008)
- Sidnell (2011) explanation of turn-taking, interruption, overlapped speeches
- Question-answer-type in history-taking by Boyd & Heritage (2006)
- Speech act categories by Yule (1996), Clealand et.al (2013)
- Felix-Brasdefer (2015), Ojha & Holmes (2010), Holmes (2008), Koester (2006) explanations on relational talk

These are parts of the approaches in Discourse Analysis (DA) that can be used to help discover the kinds of professional/social/interactional practices enacted between the involved agents also which, may influence and determine their satisfaction level with the engagement. More importantly, these inspections are much of the crucial components to be noticed primarily by the relevant stakeholders in Dental Faculty for some insights about their third-year dental students who are relatively new in the practice, having to deal with various types of patients - despite attempting for communicative improvement.

For example, analyses exemplify the choice of code or the kinds of language(s) used as a medium of communication between the different agents of different racial backgrounds, the patients' different ways of talking or reacting to the student-operators, the students' exhibition of professionalism in dealing with patients, and the student-operator management of talk at different phases with different types of patient. More of this is discussed in Chapter 4.

### 3.5. Transcription Method

The extracts are transcribed following the transcription notation listed in the following Table 3.6. This notation is adapted from Jefferson (2004) excluding the last four notations. They are intentionally added to inspect the micro-analytic detail such as time pauses, overlapping, intonation from the adjacency pair and this is to ensure the enrichment of the analysis as a whole:

Table 3.6. Jefferson (2004) transcription notation

| Notation | Example | Description |
|---|---|---|
| Speaker | P 1/2/3/4/5/6/7/8/9/10 | Patient |
| | SO 1/2/3/4/5/6/7/8/9/10 | Student Operator |

| | | |
|---|---|---|
| | SA 1/2/3/4/5/6/7/8/9/10 | Student Assistant |
| Open square brackets | [you | Overlapped talk begins |
| Colon | text: | Lengthened speech |
| Capital letters | TEXT | Louder speech |
| Underline | <u>Text</u> | Emphasized speech |
| Equal sign | Me =<br>= and | Latched speech |
| Italicized text in between stars | **P nods** | Non-verbal actions (body movements, gestures, eye gaze, facial expression, etc. accompanying speech in the line above/during silent periods |
| Period encased in parentheses | ( . ) | A pause about one-tenth of a second |
| Number encased in parentheses | ( 1.5 ) | Silence measured in seconds |
| Period | . | Falling intonation |
| Comma | , | Slightly rising intonation |
| Question mark | ? | Rising intonation |
| Up arrow | ↑ | Higher pitch begins |
| Down arrow | ↓ | Lower pitch begins |
| Up and down arrows together | ↑↓ | Pitch rises and falls within the next word |
| Heh heh, hee hee, ha ha | | Laughter particles |
| | (text) | Transcriber's best guess at an unclear utterance |
| | *(text)* | Italics represent Malay words |
| | **Text** | Selection of texts that demand additional attention are bolded |
| | **(xxxx)** | Unclear utterances |
| | ('text') | Word that is unclearly pronounced |

The original Malay and Chinese interactions (which are the only two different spoken languages found from the data sources in the study) are provided with English translations in attempt to reach a wider audience. They are translated nearly the same as the original utterances in ensuring the clarity of the participants' intended meaning of an utterance. The translation is further reviewed by the appointed language experts in ensuring the aforementioned criteria. The translation is given a smaller font and is placed next to the original utterance, in a bracket. Meanwhile, the font used for all of the extracts is 'Courier New'. All extracts taken for the analysis are done by using a purposive sampling approach. This is primarily due to the **sound quality** that not all interactions in all ten videos can be heard clearly (unfortunately one of the limitations in the study).

# CHAPTER 4: DATA ANALYSIS

## 4.1. Introduction

This chapter addresses RQ1 and RQ2. The analysis on the structure of accessible engagement is first carried out followed by the linguistic features manifested within the interactional practices. The sections are organized as below:

- Structural mapping of student-patient engagements (Section 4.2)
- Choices of code during interaction (Section 4.3)
- Address forms, pronouns and politeness (Section 4.4)
- Management of talk (Section 4.5)
- Communicative activities and manifestations in task talk (Section 4.6)
- Communicative activities and manifestations in relational talk (Section 4.7)

Section 4.4 is designed to address RQ1 while Sections 4.3 to Section 4.7 are designed to address RQ2.

## 4.2. Structural Mapping of Student-Patient Engagements

The following table depicts all phases in which the students and their patient have to undergo during Part 1 of Basic Examination and Diagnosis. Sarangi (2010)'s framework of analysis of structural mapping is used to identify the phases found in the data. The following is the flow of engagement found from the analysis and the description for each phase is as indicated in the table below:

Table 4.1: Basic examination and diagnosis (Part 1)

| |
|---|
| Phase 1: Opening<br>The student-operator/assistant invites the patient from the waiting area into the cubicle. |
| Phase 2: History taking<br>The student-operator solicits patient complaints and the medical,<br>dental, family, social information for diagnosis purposes |
| Phase 3: Physical Examination<br>The student-operator performs two types of examinations on:<br>1) The patient's head, neck and jaw (extra oral)<br>followed by<br>2) The patient's mouth, tongue, gums, throat (intraoral) |
| Phase 4: Presentation Case/Provisional Diagnosis<br>The students deliver a presentation case to the supervisor. Data is not accessible. |
| Phase 5: Closing<br>The goodbye-thanking exchanges between the students and their patient. |

### 4.2.1. Phase 1-2: Opening to History Taking

Interactions between the student-operator and the patient for all engagements transpired the most at the beginning of session towards the history-taking phase; Phases 1 to 2. Here, the participants initially enact relational talk before steering into task talk, or towards the beginning of history-taking. The data reveals that the kind of relational talk expressed varies across participants where talkative patient may sometimes joke with the attending students. They may also initiate topics when in momentary pauses. Students focus on their tasks, preparing for the relevant equipment to work on their patients. These features in the initial phases of the clinical engagement are shown in

Extract 4.1:

Extract 4.1. Malay female student-operator and student-assistant & Chinese male patient

1. P1: After ( . ) *sakit, I lari ah*: **SO1 is not present** [After pain, I run ah..]
2. SA1: ha ha ha **Snickering**
3. P1: *Boleh?* [Can?]
4. SA1: *Tak boleh* [Cannot] ha ha ha **while snickering and shaking her head**
5. P1: Aiyoooo: ……. **while gazing to his left side**
6. SA1: *Tak sakit . :* [Not painful...]
7. P1: *Ya lah.* ↓ *cakap saje.* ↓ [Yea..I just say it..]
   (0.7)
8. P1: So how long would the whole thing take today err : Dr : Ai**** : You said 2 to 3 hours yah? ↑ **facing Dr. Aishah who just enters the cubicle and sits on the chair**
9. SO1: Yeah ↑↓ normally, each session would take about 3 hours.
10. P1 : [wow
11. ( . )
12. SO1: But if we can finish early : ↑↓ then :
13. P1: Aaa: 3 hours that means, long: process wooh.. what you do to me? Can give uhh ( . ) G.A or not **stick tongue out** let me sleep.
14. SA1: [ G. A ?
15. P1: Yeah. Let me [sleep la, ya. just *tidur* [sleep] lah.. ( . )]
16. SO1: [No : ↓ No : ↓ ( . ) ]
17. P1: Then you do whatever you'll have to do lah:
18. SO1: But we have to ask you questions… ↑↓
19. P1: Aiyoo : *sakittt*:↑ [Aiyoo, painnn]
20. SO1: *Tanya soalan* ↑↓ *je tak sakit lahhh :* ↑↓ [ask question only, no pain lahhh]
21. P1: *Sakitt :* ↑ [pain]
    **Serious face but joking**
    **Both dental students snigger**
22. SO1: Uhhh..Should I call you uncle? **while putting the gloves on**
23. P1: = Eh don't la : [can ah no problem]. no problem **smiling* saya pun sudah 60=* [I'm already 60]

24. SO1: [hmmm] *adjusting her hand gloves*
25. P1: = senior citizen... [you respect] the (xxx).
26. SO1: [uh hmm
27. P1: = If you want to call me Mr. also I don't mind. How old are you?
28. SO1: Aaah : Twenty : two
29. P1: Very good. *pointing the SA* She?
30. SO1: Just the same
31. P1: So : How long ( . ) will all of you graduate? *while doing hand gestures*
32. SO1: Two more years.
33. P1: Wahh ↑ *claps*
34. P1: Dr. Afifah : She'd been tied down for 10 years. So now she's third year already ah. She got [7 more years].
35. SO1: [Ah I see : ] =
36. P1: = You know her? Your colleague. Afifah. She's the one who: *SO1 and SA1 speak with each other about the 'mentioned' person. Though, their interaction here is unclear*
37. P1: ( . ) You all local? From KL?
38. SO1: Uh : No. I'm from Kuantan.
39. P1: Huh very good. You come here, you escape the bow side. You? *pointing the SA1*
40. SA1: = I'm from Terengganu.
41. P1: *Terengganu? Wow la:gi best. cantik woo. The beach there, pantai. Sini westcoast ( . ) (shake his head) kotor la. Sana : pantai: putih ah?* [Terengganu? Wow more exciting, beautiful woo. The beach there, beach here, west coast is dirty la. There white beach ah?]
42. SA1: Mhmm *nodding*
43. P1: *Sana:pantai sand ahh*? Quite sand *ah? Sini:* Here all are conta:minated by all :the vessels, all the way from the straits of Malacca*. Kotor sangat:* [There, the beach sand ah? Quite sand ah? Here, all are contaminated by all the vessels, all the way from Malacca. Very dirty.]
*SO1 abruptly gets up from her chair trying to find something*
*SA1 speaks to SO1 pertaining to the 'missing' something*
(0.15)
*P1 *Turn his head gazing the D.O1*
44. P1: *Ni Syira, dia selalu ada ini macam ke interview ahh?* ↑= [This Syira, is she always having this practice? interview ahh]
45. SO1: = *Takk [No]* = first time = this is first time
46. P1: Woo. I very lucky ↑ *putting his hand on his left chest*. So I'm lucky. ↑

47. SO1: Yeah .hhh Lucky] ↑ ( . ) lucky ↑*grins*
48. SA1: [Heh heh heh first ↑
49. P1: *Ada (.) dia nak bayar saya?* [Is there any chance that she pays me?]
50. SO1: ↓ *Tak tahu la..* [I don't know]
51. ( . )
52. P1: *Belanja makan ke.. Nasi ayam [pun takda?]* *[Treat me with food.. Chicken rice also doesnt have?]*
53. SO1: Tak tahu la,,. (grins) You ask her lahh] [I don't know. You ask her lahh]
**Both students are getting ready for the history-taking session. They are seen to prepare all equipment needed for the session**
54. P1: Just kidding laaahh …. ↑↓ **grins and hand gesture indicating 'no'** Kita support...kita support... ↑↓ ( . ) *Apa apa acara kita kena support kan...*while D.A1 ties an apron on this patient's shoulder*. Untuk pertolongan semua semua* [Just kidding lah, We support, we support. Any events we have to support right. To help everyone]
**Both students seem to double check everything and getting started for the session**
55. SO1: Mhmm.
(0.7)
56. SO1: So uncle: do you have any complaint or any pain? = (mins 2.48)
57. P1: = After Afifah did? =
58. SO1: = Aha =
59. P1: = [No.
60. SO1: [No pain.

From the above example, this 'friendly' patient occupies the silence gap by conversing and expressing interests with his attending dental students before all participants could begin with the business of the meeting, i.e., history taking. The same patient makes an effort by opening ways to informality, initiating a number of different small talk and relational practices in his turns. This practice aids him in developing intimacy, rapport building and affinity with the students.

This occurrence is noticeable from line 1 when the patient jokes to the student-assistant about how he would later runaway if he experiences pain during his treatment.

The student-assistant responds by laughing in lines 2, 4 and 6. While doing relational talk, task talk is also seen intertwined when the patient breaks the silence (line 8) and probes about the time duration for the whole session (line 9). Having become aware of the time length informed by the operator in the next turn, the same patient keeps teasing the students. However, in lines 19-22, the student-operator tries to get the patient to participate in task talk. From the survey interview with this patient, he mentions that he purposely teases the students as that significantly helps him to feel at ease and more relaxed since he feels anxious on the dental chair. Apart from laughter, agreement, appreciative laughter, Hyland (2013) contends that teasing helps participants to establish solidarity amongst themselves. This also influences patient's perspective and level of satisfaction with the service.

In line 22, the student-operator proposes to be in a conventionally polite circumlocution that she closes the previously joking episodes by initially expressing a filled pause *'uhhh'* and further enquiries the patient on his salutation preference – whether he accepts the 'offer' or 'opinion' (realization of auxiliary verb *'should'* at the initial query*)* to be addressed as *'uncle'*. Again, the patient keeps teasing the operator by voicing *'eh don't la'* in the beginning but further cuts the 'frivolous' claim by consenting to be addressed so. This implicitly reveals their consensus in effort to lessening any form of relative power and distance. In the same line of utterance, he also supplements his reason of approval when he says 'no problem' (line 23). At this juncture, the student-operator attends to the patient's utterances and enacts courtesy by verbalizing a minimal agreement token *'uh hmm'* (line 26). The patient further continues with relational practice by proposing another new topic in a small talk related to students' background, and he asks them their age and hometown in lines 28 to 43.

As the interaction progresses, there is a noticeable shift after a slight pause in line 58 from relational talk (joking) to the talk related to the business of the visit; task talk

when the student-operator explicitly poses the first question to her patient, also marks the beginning of a history-taking session (line 56-60). All participants portray their readiness for the interview session and start with a history-taking session.

Another example of interaction that is transpired during the opening into history-taking is as follows:

Extract 4.2. Chinese male student-operator, Malay female student-assistant and Sikh male patient

| | | |
|---|---|---|
| 1 | SO5: | Hi uncle ↑ (*shake hand) Jov*** = |
| 2 | P5: | Hi. So she told me that you're from Sarawak. = |
| 3 | SO5: | = Yea I'm from Sarawak.= |
| 4 | P5: | = So am I, |
| 5 | S05: | Oh really? ↑ = |
| 6 | P5: | = Yeah. = |
| 7 | S05: | = Which part of Sarawak? = |
| 8 | P5: | = Kuching. You? = |
| 9 | SO5: | = I'm from Kuching too. ↑ = |
| 10 | P5: | = Dekat : mana? = |
| 11 | SO5: | = Uh: dekat : Bau. = |
| 12 | P5: | = Oh you're from Bau.= |
| 13 | SO5: | = Yeah = |
| 14 | P5: | = Saya : on the way to Bau. : Betul betul, tengah [I..exactly at the centre of..] |
| 15 | SO5: | = Oh,: yeah the ___ = |
| 16 | P5: | = So the third : bow. So not very far from there = |
| 17 | SO5: | = Yeah bow la *nod* |
| 18 | P5: | So how long you' have been here doing this? |
| 19 | SO5: | Uh: ↓This is the: third year. |
| 20 | P5: | *nod* = Okay uh : |
| 21 | SO5: | Aha, Yeah. I would like inform you one thing: before ↑↓ I start with denture thingy right ↑↓ |
| 22 | P5: | = Right |
| 23 | SO5: | I'll be doing all the treatment on your teeth with (xxx) la. So after I do the cleaning and everything, then I will do the [examination] = |

Here, the Sikh patient immediately initiates small talk with his student-operator soon after they shake hand, and then the patient asks about the student's hometown (line 2). The

small talk progresses until line 20. The student-operator shifts into the business of history-taking in lines 21-23. The student-operator clarifies the procedures they will undergo for the session (line 21, 23). The length of small talk in this example, however, is not equally as long as in the previous example.

### 4.2.2. Phase 3: Physical Examinations: Extraoral and Intraoral Examinations

In this phase, the student-operator examines the patient's head, jaw and neck before proceeding with an examination on the patient's mouth. Relational talk is not common, but in one instance, it was initiated by a talkative patient. Additionally, there are speech acts employed by the student-operator in achieving the goal of extra oral examination when interaction is claimed to be minimal (Clealand et al., 2013).

One example of the student-patient interaction from the data in this phase is as follows:

Extract 4.3. Malay female student-operator and student-assistant & Chinese male patient

| | | |
|---|---|---|
| 1 | SO1: | Uncle *boleh tak masukkan tiga jari mcm ni..* ha..[Uncle can you put your three fingers inside like this, ha..] |
| 2 | SO1: | Ok. |
| 3 | P1: | First time woo. *Ni untuk apa?* [What is this for?] |
| 4 | SO1: | *Ni untuk..* check temporal. [This is for.. checking temporal] |
| 5 | SA1: | *Nanti angin kat sini* [you'll feel the air here] **pointing ears* *doing examination on the patient's head** |
| 6 | P1: | First time I try *ini..* [First time i try this] |
| 7 | SO1: | *Sebab* sometimes *ada orang tak boleh masuk* [Because sometimes there are people who can't *fit the fingers inside their mouth*] |
| 8 | P1: | *Yaka?* [really?] |
| 9 | SO1: | *Itu sebab block*[because it's blocked] |
| 10 | SO1: | *Ha. Macam nak check uncle ada problem kat sini ke.. kat sini kee* [Like, want to check if you have problems here, or here] **pointing parts of head and neck** |

The excerpt illustrates an interaction where the student-patient engages in the extraoral examination. In line 3, the patient asks the reason for inserting his three fingers inside the mouth. Both of the student-operator and student-assistant provide answers to his question (line 4, 5). The student-operator proceeds with an examination on the patient's head. The patient in line 6 explains how it is the first time he undergoes such a procedure. The student-assistant then responds by explaining the reason for such a procedure.

Thereafter, the next procedure after the extraoral examination is the patient's mouth examination. Here, the interaction only takes place between the student-operator and the student-assistant. The operator says some technical diagnosis for the assistant to key into the computer. There was one engagement in the data showing a brief interaction between the student-operator and her patient, while waiting for the students' attending lecturer to consult the patient's case presentation. This is shown below:

Extract 4.4. Malay female student-operator and student-assistant & Chinese male patient

| | | |
|---|---|---|
| 1 | P1: | Ok. Uh.. Dr. Aishah. Will you clawing?= |
| 2 | SO1: | = huh? (come close to patient) |
| 3 | P1: | =*Mau buat clawing ka?*= [Do you want to do clawing?] |
| 4 | SO1: | =*ha uncle uncle nak ke*= [uncle, you want it?] |
| 5 | P1: | =I don't know. U: advise me.= |
| 6 | SO1: | =*kalau nak:*= [if you want..] |
| 7 | P1: | =*satu: atau dua?* = [one or two?] |
| 8 | SO1: | Uh: for this case. Only [one lah *sekarang* |
| 9 | P1: | [one la |
| 10 | SO1: | *sebab I kena* [*because I have to*] continue on your **R2** first. |
| 11 | P1: | Yeah: |
| 12 | SO1 | then: then u can request on the other day |
| | | (*interaction progresses) |
| | | (*supervisor/doctor comes into the cubicle) |

While they waited for the students' supervisor to attend to them, the patient asks what will happen to his teeth, and the patient seeks the students' advice on what needs to be

done to rectify his issue. They talk until the supervisor appears in the cubicle for the supervision purposes.

### 4.2.3. Phase 4-5 : Presentation Case/Provisional Diagnosis to Closing

Phase 4 takes place when an initial diagnosis about the patient's case is made. However, the data is not accessible as the doctor is involved (as explained earlier, the ethics approval does not allow doctors to be recorded). If the act of history taking or examinations requires long hours or if the presentation is not satisfactory to the attending doctor that continuing to 'Part 2' is not possible, the participants are required to continue/passage their route into closing phase – phase 5.

The data reveal that Phase 5 is typically brief, where the student-operator will remind the patient pertaining to dental concerns (task talk). This is shown in line 1 of Extract 4.5. This is then followed by relational talk, in the form of ritualistic thanking exchanges in line 3, 7.

Extract 4.5. Malay female student-operator, Chinese female student-assistant & Chinese female patient

| | | |
|---|---|---|
| 1 | SO3: | ***Ok: so dah habis dah: nanti I panggil you untuk sesi akan datang: lepas tu kita scaling.*** [Ok... so finished already. Later I'll call you back for the next session and then we will do scaling] |
| 2 | P3: | *Aha ok. Sekarang bole balik.* [Aha ok. now i can go}<br>**getting up on her dental chair** |
| 3 | SO3: | ***Thank you for coming:*** |
| 4 | SO3: | *Nanti apa apa: Nanti hantar tau gambar.* [Anything, later send me pictures yeah] |
| 5 | P3: | Ha: |
| 6 | SO3: | OK. |
| 7 | SO3: | **Thank you arr: for coming.**<br>*SO3 walks the patient out* |

Likewise, the same reminder and suggestion pertaining to the dental matters is brought up by the student-operator in line 2, Extract 4.6 below. He reminds the patient about how she can have the same students to attend her, on her planning for tooth extraction in the near future. A small talk is embedded in line 3-9 before the thanking exchange (denoting the closure). This is initiated by the students and the patient in line 10 and 11 simultaneously:

Extract 4.6. Malay male student-operator and student-assistant & Malay female patient

| | | |
|---|---|---|
| 1 | P7: | *Dah ke?* [Done?] |
| 2 | SO1: | *Dah dah. Nanti kalau acik nak cabut dengan kitorang pun boleh jugak. Tapi kena datang awal la.* [Done done. Later if aunty wants to do extraction with us also is possible. But you have to come early] |
| 3 | P7: | **nod* Dah kan* [Done right?]<br>*getting up from her dental chair* |
| 4 | SA7: | *Barang tak ada tinggal kan?* [No any belonging is left right?]<br>**checking her things and fixing her shawl**<br>**all of them are standing facing each other** |
| 5 | P7: | *Apa nama awak eh?* [What is your name?] |
| 6 | SO7: | F****** |
| 7 | SA7: | E**** |
| 8 | P7: | E***? |
| 9 | SA7: | **spelling out his name**<br>**a small discussion about extraction of tooth but utterances are not clear because participants are quite distant from the recorders* |
| 10 | P7: | ***Ok lah. Terima kasih eh*** **[Ok, thanks]** |
| 11 | SO7 & SA7: | ***Sama-sama*** **[Welcome]** **smile and nod at the same time** |

### 4.3. Choice of Code During Interaction

Since the live-setting of this study constitutes multi-racial individuals of the healthcare providers (students) and clients (patients), linguistic variations and a variety of dialectal speeches of interactions can to be expected (Baskaran, 2005, David, 2006 & Njoroge, 2011). However, the lingua franca used during clinical engagement in FoDUM is not fixed or definite amongst the students and their patient. This is because it primarily relies on the preferred language proposed by the patient who come from different ethnic and linguistic background, dissimilar with that of the attending students (especially the student-operator).

In the interview session, the dental students report that they try to accommodate to their patients' ways of talking and language. This corresponds to the idea by Teh & Chu (2005) who reports that the doctors accommodate to the patient's speech to show respect, closeness, and it acts as a strategy to reduce anxiety. The student-operators also mention that they would seek help from their student-assistant or other colleagues to do translation should the occurrence of language breakdowns arises. There is no instance from the collected data showing these issues.

This section scrutinizes one important linguistic register available from the data, featuring the students and their patients who do not share common first language. Out of all ten engagements, three engagements feature participants (specifically) the student-operator and the patient who are from the same ethnic and linguistic background of Malay and Chinese individuals. Two engagements feature the Malay student-operators and their patients who fully speak in Malay while another one engagement featuring a Chinese operator and a Chinese patient speak in full Mandarin.

The other three engagements feature a student-operator and a patient who are dissimilar in terms of race and their first language, but they interact in Malay. Two

engagements consist of a Chinese and an Indian patient who barely speaks Malay (noticeable from observation, interview and analysis of their talking), so they use a low-Malay/ Bazaar Malay variety.

Another three engagements feature participants who differ in their first language used 'code-switching' as a technique to interact with one another. They are found to code-switch between Malay and English languages. The last engagement with participants from different background however, uses Standard English while interacting. The following Table 4.2 illustrates these descriptions made:

Table 4.2. Mapping of engagements in discovering the spoken language(s) used

| |
|---|
| First three engagements who fully speak in Malay/Chinese:<br>i) Two Malay student-operators, two Malay student-assistants and two Malay patients (use Malay)<br>ii) One Chinese student-operator, one Chinese student-assistant and one Chinese patient (use full Mandarin) |
| Another three engagements:<br>i) One Chinese student-operator, one Malay student-assistant and one Malay patient (use Malay)<br>ii) One Malay student-operator, one Chinese student-assistant, one Chinese patient (use Bazaar Malay)<br>iii) One Chinese student-operator, one Chinese student-assistant and one Indian patient (use Bazaar Malay) |

| |
|---|
| Another three more engagements:<br>i) One Malay student-operator, one Malay student-assistant and one Chinese patient (code-switch between Malay & English)<br>ii) One Malay student-operator, one Chinese student-assistant and one Chinese patient (code-switch between Malay & English)<br>iii) One Malay student-operator, one Chinese student-assistant and one Malay patient (code-switch between Malay & English) |
| The last engagement:<br>i) One Chinese student-operator, one Malay student assistant and one Indian Sikh patient (English) |

The following analysis section is better depicted under the following subsections/categorization:

- Code-switching: Malay and English Languages (Section 4.3.1.)
- Standard and Low Variety Malay/Bazaar Malay (Section 4.3.2.)
- Standard Malay, English and Mandarin (Section 4.3.3.)

### 4.3.1. Code-Switching: Malay and English Languages

Individuals in some circumstances might choose a particular language or dialect when interacting with others as what many sociolinguists termed as ‘code’. Specifically, ‘code-switching’ is the usual term used between the speakers who use more than one linguistic variety while interacting. It is the condition in which bilingual or multilingual speakers alternate between two or more languages, or language varieties, in the context of a single/same conversation (Myers-Scotton, 1993:4 as cited in Cantone, 2007).

Multilingual speakers at times would opt to use or apply elements of various languages to interact with other speakers. The previous statement corresponds with three findings from the data that shows the student-operator/assistant and patients who do not share similar first language but tend to code-switch when interacting. This is evident in the following extract:

Extract 4.7. Malay female student-operator and student-assistant & Chinese male patient

| | | |
|---|---|---|
| 1 | P1: | **Yeah. Let me [sleep la, ya. just *tidur lah*:** [Just sleep lah] ( . )] |
| 2 | SO1: | [No : ↓ No : ↓ ( . ) ] |
| 3 | P1: | Then you do whatever you'll have to do lah |
| 4 | SO1: | But we have to ask you questions… ↑↓ |
| 5 | P1: | Aiyoo : *sakittt* : [Aiyoo, painnn] ↑ |
| 6 | SO1: | *Tanya soalan* ↑↓ *je tak sakit lahhh* : ↑↓ [Ask question only, no pain lahhh] |
| 7 | P1: | *Sakitt* :↑[pain] |

The student-operator in Extract 4.7 is a Malay female while her patient is an elderly Chinese man. They code-switch between Malay and English languages throughout their whole interaction and engagement. Additionally, this can be implied that 'code-switching' is their preferred mode of interaction with each other. The patient and the student speak colloquial Malay, making the interaction more casual and friendly.

The example of practice between another Malay female student-operator and her elderly Chinese male patient is evident in the following extract:

Extract 4.8. Malay female student-operator, Chinese female student-operator & Chinese patient

| | | |
|---|---|---|
| **1** | **SO4:** | **You *sihat?* [Are you doing fine/well?]** |
| **2** | **P4:** | ***Sihat sihat..*** **[Fine, fine]** |
| 3 | SO4: | *Dah* breakfast *dah*? [Have you taken your breakfast?] |
| 4 | P4: | *Dah dah* [Yes I have] |

| | | |
|---|---|---|
| **5** | **SO4:** | **Because *harini*: I *akan* just uhh: *tanya* you history *semua untuk* data. Then for another treatment then start with the treatment lah. Oh, for today no treatment lah eh, just to collect your data..** [Because today, I will ask you about your history for data purposes and then we will start the treatment. Oh, for today no treatment but just to collect data] |
| 6 | P4: | **nod** |
| **7** | **SO4:** | **So Mr. ***, do you have any complaint for your oral health?** |
| **8** | **P4:** | **Not at the moment. *Terlampau banyak* [Too many] (*laugh)** |
| 9 | SO4: | So: for today's concern: Just for regular checkup? |
| 10 | P4: | Ok, yes. ok. **nod** |
| 11 | SO4: | No pain: **hand gestures – waving indicating 'no'** |

From Extract 4.8, the student-operator and the patient (in bolds; lines 1-2) who are still at their early phase of engagement interact in Malay before they code-switch into English from line 5 to 11. The switch was initiated by the student-operator. Another instance of code-switching is also found between a Malay female student-assistant and her Sikh elderly male patient, as shown in the following extract:

Extract 4.9. Malay female student-operator and student-assistant & Chinese male patient

| | | |
|---|---|---|
| 1 | P5: | **So: where do you plan to go after this? Hoping: where are you: *tempat yang you suka?*** [the place that you like?] |
| 2 | SA5: | (*chortles) Umm: I: dont know yet: |
| 3 | P5: | **Maybe Sarawak? *Suka pergi* Sarawak?** [Do you like to go to Sarawak?] |
| 4 | SA5: | **Haha oh *tak*** [no] **no no** (*hand gestures showing 'no') that's too far: |
| 5 | P5: | *Pernah pergi Sarawak? Maybe jauh: tapi dekat sejam boleh sampai*. [Have you ever been to Sarawak? Maybe far, but you can reach there within an hour] |
| 6 | SA5: | I'm from Ipoh. |

Similarly, the Sikh patient and the student-assistant who engage in a small talk in Extract 4.9 code-switch between Malay and English languages – as evident from the italicized and non-italicized words/phrases. The patient does the Malay code-switching more than

the Malay student-assistant does – as she speaks more English with him during her speaking turns. Though so, she is also occasionally found to code-switch in Malay when interacting with her patient (e.g. in line 4 above 'when she utters *'tak'* [no]).

### 4.3.2. Standard and Lower Variety Malay/Bazaar Malay

This section reveals a different occurrence when a Chinese female student-operator talks with her Indian female patient who prefers interacting in Malay. This is also due to the fact that Malay is the only common language shared by the participants involved. On the student-operator's side, she interacts in formal standard Malay while the patient uses a lower variety of Malay. Morais (1998) categorizes such Malay variant as Bazaar Malay in which the pronunciation and intonation of the spoken Malay are influenced by the first or ethnic language. In the interaction, the patient inserts lexical items of her ethnic language into Malay. This could also be due to her limited knowledge of Malay. This is shown in the next extract:

Extract 4.10. Chinese female student-operator, Chinese male student-assistant & Indian female patient

1 SO2: *Ini apa you makan ubat ni: puan inject: so inject dekat sini*

*lah?* [What is it the medicine that you have been consuming? So, you do the injection here?]

2 P2: *Aha..*

3 SO2: *Er.. tau tak ubat tu apa?* [Do you know what is the medicine?]

**4 P2: *Ubat yang ni malam punya: macam kuning macam: ada la kuning:***

***ini macam kaler: ini pagi punya putih*** **[This medicine is for night, yellowish. It's like yellow color. Like this color... the white one is for morning]**

5 SO2: *Ohh dia injection 2 kali? Pagi satu?* [So injection two times? One in the morning?]

**6 P2: *Pagi: tengahari: aaaa: tidur kan.yang ni tidur. Pagi: pagi: aaaa***

***tengahari yang ni tidur..Pukul 7* [Morning, noon.. and this one is sleeping pills. Morning....noon, and this one is for night. Consume at 7pm]**

7 SO2: *Pukul 7?* [At 7?]

8 SO2: *Untuk tidur? Oh mmg kena:?* [For sleeping? Oh is it necessary …..]

9 P2: *Lagi satu malam tidur.* [One more is at night]

The bolded sentences illustrate the responses given by the patient in Bazaar Malay about the referred medicine, asked in line 3. In this Bazaar Malay/lower-variety of Malay, the patient constructs the sentence structure and the frequent usage of the discourse particle/lexical item "*macam* [like]" in between the alternating phrases (line 4). This is parallel to the fact pointed by Morais (1998) who explains that the dominant Malay used amongst some Chinese or Indian communities is assisted with some occasional lexical items from the speaker's ethnic language. Meanwhile, another extract featuring a Malay female student-operator and her Chinese female patient also shows that spoken Malay language is used as a preferred mode of interaction, as requested by the patient.

Extract 4.11. Malay female student-operator, Chinese female student-assistant & Chinese female patient

1 SO3: *Bila you sedar yang gigi you patah?* [When did you realize that your tooth broke?]

2 P3: *Er..Sudah beberapa bulan lepas **wohh:*** [Err.. it has been few months ago]

3 SO3: *Lama la:* [long time already]

4 SO3: *You datang kat sini ke? Yang haritu tu?* [You came here? The other day?]

5 P3: *Macam: bulan lepas **ahh**: macam tu lah:* [like.. last month, like that]

6 SO3: *Gigi yang pecah tu kan: ada sakit tak? Apa apa ke..* [the broken tooth, does it hurt? Or anything?]

7 P3: *Tak ada..* [no]

The interaction in Extract 4.11 is found to be quite similar with the previous extract. The dominant Malay language used by the patient can also be distinguished as the version of Bazaar Malay/lower-variety of Malay through the apparent form of Chinese phonological variation. This includes unique discourse particles/lexical items such as “wohh” “lor” “ahh” which are the discourse particles often inserted in Malay Chinese language/dialect.

### 4.3.3. Standard Malay, Chinese Mandarin and English

In two student-patient engagements, Standard Malay was used as a preferred mode of interaction by the student-operator and the patient who share similar a common language. This is shown in Excerpt 4.12.

Extract 4.12. Malay male student-operator, Malay male student-assistant and Malay female patient

| | | |
|---|---|---|
| 1 | P7: | *Umur berapa ni korang?* [How old are you all?] |
| 2 | SO7: | K*itorang lagi muda dari tu lah.. *small laugh* 22..* [We are still young than the....22] |
| 3 | P7: | O*h..mudanya* [Oh, so young] |
| 4 | SO7: | ***Acik** ada complain apa apa tak?* [Do you have any complaint aunty? |
| 5 | P7: | *Hmm tak..* [hmm no] |
| 6 | SO7: | *Pernah tak cakap pasal rawatan akar tu..* [Have you spoken about the root canal treatment?] |
| 7 | P7: | *Ada lah..* [I have] |
| 8 | SA7: | *Tapi memang nak rawatan akar lah kan..* [But you do want to undergo the treatment right?] |
| 9 | P7: | *Ha boleh la kalau nak buat..* [Yes can if I want to] |
| 10 | SA7: | *Sakit tu..* [That is going to get hurt] |

The participants in Extract 4.12 are all the Malays. From lines 1-10, all participants use spoken Malay language when interacting. They do not code-switch Malay with any other languages. Likewise, the same manifestation also can be found in Extract 4.13 when the

Malay student-operator speaks in Malay with her male patient - who happens to be her biological father:

Extract 4.13. Malay female student-operator, Chinese female student-assistant and Malay male patient

1 SO10: *Uhh, last.* ***Ayah*** *jumpa doktor gigi buat apa eh?* [Uh, last time when you met the dentist what did you do yea, father?]

2 P10: *Er..masa buat..scaling. Mungkin..bulan Mac* [When I was doing the scaling, probably in March]

3 S010: *Mac tahun bila?*

4 P10: *Tahun ni.* [This year]

Extract 4.14 below illustrates an instance in which the Chinese female student-operator and her Chinese patient (who is also her biological father) interact in Chinese Mandarin:

Extract 4.14. Chinese female student-operator, Malay female student-assistant and Chinese male patient

1 SO8: **漱**口先 [gargle first]

2 SO8: **戴**眼镜 [wear the goggles]

3 P8: **可**以不要戴眼镜？[must I wear the goggles?]

4 SO8: 这是一定要的 [it's a must]

5 SO8: **要**脱掉这个才可以 [you must first take this off]

The last instance shown in Extract 4.15 below features a Chinese male student-operator and his elderly Sikh male patient who wholly interact in Standard English throughout the course of the dental engagement. The lines of English utterances are spoken by the participants in lines 1-8:

Extract 4.15. Chinese male student-operator, Malay female student-assistant and Sikh male patient

1 SO5: So: you've been admitted to hospital right? 10 years back?

2 P5: Yeah: for my heart.

3 SO5: For the heart.

4 P5: For my heart. I have two stains. I have two stains

5 SO5: For your heart.

6 P5: For my heart.

7 SO5: Asthma as well?

8 P5: Yeah I also have asthma.

## 4.4. Address Forms, Pronouns and Politeness

Yoong (2010) in his work explicates that the speakers' social identity and roles in a professional setting can be determined from the use of referent terms or specific address forms or 'profession' title - as the word or words used in writing or speech to address these interlocutors (Dai, 2002) such as doctor, teacher, inspector and to name a few. The use of specific address form or referent term also defines the kinds of relationship involved between the speakers - e.g. whether intimate or distant relationships.

Having mentioned this, this section explores another linguistic register available in the data as part of the interactional norms in the multilingual dental setting, specifically on the use of address forms or pronouns used by the students and patients-participants when addressing each other. This section is arranged as in the following:

- Addressing the students (Section 4.4.1)
- Addressing the patients (Section 4.4.2)

### 4.4.1. Addressing the Students

There are two address forms used by the patients in addressing the dental students – if not, the pronoun 'you' or its Malay equivalent *'awak'* is used. The students are yet, actual dentists and they are much younger than the patients. However, one engagement from the data recordings evidently shows that the student-operator and student-assistant are mainly addressed as 'doctors' by their attending patient. Such practices depict an expression of

politeness in which one is addressed by considering and respecting the status differences. In this case, each student posits a higher status by considering their role in the setting. The other four remaining patients are similarly found to address their attending students by such a 'profession title' as discovered from the interview surveys. The other five patients nonetheless are not heard referring their attending dental students by any address form. In line 1, Extract 4.16, the male Chinese patient addresses the Malay female student-operator and her assistant as "Doctor":

Extract 4.16. Addressing the female student-operator as "doctor"

1 P1: Ok. Uh: **DR. Ai*****. Will you clawing?=
2 SO1: = Huh? *coming close to the patient*
3 P1: =*Mau buat clawing ke?* = [Want to do clawing?]

In Lines 1 and 3 of Extract 4.17, the pronoun "*awak*" ('you') is used by the patient in addressing both of her attending students when she asks them for their name:

Extract 4.17. Addressing the male student-operator and male student-assistant as "awak"/'you'

1 P7: ***AWAK*** *nama apa?* [What's your name?] **facing the operator**
2 SO7: F******
3 P7: ***AWAK?*** [You?] **facing the assistant**
4 SO7: E******

### 4.4.2. Addressing the Patients

Meanwhile, the address forms used by the students to their patients range from formal to informal forms, and they can be types of politeness. Being in a multilingual setting allows the students to opt for any address forms or kinship terms in different languages. The choice is influenced based on the consideration of their patient's social and status differences, disparity of ages, social relationship, degree of solidarity. Consider the

following extracts involving different student-operators and their patient who (as mentioned) do not share similar social and linguistic backgrounds:

Extract 4.18. Addressing the male patient as “uncle”

1 SO1: **UNCLE!** Er: You know what floss is?
2 P1: Yes?
3 SO1: Floss. *Cuci*. [clean] Floss.

Extract 4.19. Addressing the male patient as “uncle”

1 SO5: Hi **UNCLE** ↑ **shake hand** Jov*** =
2 P5: Hi. So she told me that you’re from Sarawak. =
3 SO5: = Yea I’m from Sarawak.=

Extract 4.20. Addressing the male patient as “Mr”

1 SO4: *So harini sihat.. **MR**. *** sihat?* [So today you’re fine, you’re doing fine **Mr**.?]
2 P4: *Sorry...?*

The three extracts above feature a student-operator and a patient with different backgrounds. The first two extracts, Extract 4.18 and Extract 4.19, show the use of intimate kinship address form or ‘honorific’ “uncle” instead of a formal “mister”. In context, this reduces social distance and/or the relative power/status.

This is however a different case in Extract 4.20, when the male elderly patient is addressed by the following address form “Mr.”, which is a general, formal address form for a male interlocutor. This maintains status and gaps differences. On the other hand, the vocalization of “ayah” (‘father’) is used by the student-operator who happens to be her father as the patient. “Ayah/Father” is an address form commonly used for a male close relative - a biological father in the Malay society. This example is shown in Extract 4.21 below:

Extract 4.21. Addressing the male patient as "*ayah*"/'father'

1 SO10: *Uhh, last.* ***AYAH*** *jumpa doktor gigi buatpe eh?* [Uh. Last time when you met the dentist what did you do eh father?]

2 P10: *Er: masa buat: scaling. Mungkin: bulan Mac* [Er. When I was doing the scaling... Maybe in March]

On the other hand, the female 'stranger' as the students' patient is addressed by the following individual address form as depicted in the extract below:

Extract 4.22. Addressing the female patient as "*puan*"/'madam/

1 SO2: ***PUAN*** *ada darah tinggi kan? Puan pernah tak jatuh…* = [**Madam** you have blood pressure right? Have you ever fallen down?]

2 P2: = *Takda.*= [nope]

3 SO2: = *Lepas tu ada sakit jantung ke?* = [And then do you have a heart disease?]

4 P2: **head indicating no**

The extract above features a Chinese student-operator who uses ***"Puan"*** ('Madam') as in Line 1, Extract 4.22 when addressing her middle-aged Indian female patient. This inwardly signals her sense of deference by considering the status differences with her female patient.

Meanwhile, the expression of the informal cultural address form "Acik" in Malay language is used by one male operator to his elderly Malay woman patient. "Acik" is a short form or an abbreviation from the word 'Makcik' ('Aunty' – address form for woman who is much older) and this is as shown in Extract 4.23 below:

Extract 4.23. Addressing the female patient as "makcik"/'aunty'

1 P7: *Dah ke?* [Done?]

2 SO7: *Dah dah. Nanti kalau* ***ACIK*** *nak cabut dengan kitorang pun boleh jugak. Tapi kena datang awal la.* [Done done. If **aunty** wants to extract with us also is possible. But have to come early]

3 P7: **nod* Dah kan* [Done right] **getting up on her dental chair**

The following extract illustrates another move of displaying politeness through the choice of address form “kak” - the short form for ‘kakak’ in Malay (‘sister’ in English) as the intimate and common form used by an individual when addressing a female stranger. This address form is used by the Chinese male operator with the female Malay patient who is only slightly older than him:

Extract 4.24. Addressing the patient as “kak”/’sis’ - clipping from the word ‘kakak’ and ‘sister’

1 P9: *Uh huh, boleh lah.* [uh huh, okay lah]

2 SO9: ***(xxxx)***

3 SO9: *Umur berapa* ***KAK?*** [what’s your age **sis**?]

4 P9: Twenty-nine.

The last extract below, Extract 4.25 shows one engagement in which the pronoun “you” is used by another Malay female student-operator when addressing her Chinese female patient whose age gap is relatively small. The English first person pronoun “you” is chosen even when Malay language is used as the mode of interaction between the participants. This is shown in Line 1 and 3, Extract 4.25 below:

Extract 4.25. Addressing the female patient as “you”

1 SO3: *Ramai nak buat la: ↑↓Doktor akan diagnose: macam: doktor akan tengok lah. ↑↓****YOU*** *betul betul need: Perlu sangat pakai ke:. tak perlu pakai sangat ke apa:* [Many patients intend to undergo this phase. Doctor will diagnose. He/she will see whether you really need this or not]

2 P3: Ahaa:

3 SO3: *Tapi kalau* ***YOU*** *nak untuk diagnosis gigi tu kan, nanti I boleh refer kat sini la..sini ada buat la..* ***YOU*** *nak ke?* [I can later help you if you need the oral diagnosis. We do have that here. Do you want it?]

4 P3: *Ok boleh la.* [okay sure]

5 SO3: *I boleh: ↑↓ nanti I boleh refer kat sini la.* [I can, I can refer about that (diagnosis) here]

## 4.5. Management of Talk: Turn-taking, Interruption, Overlapping Speech, Latches

It is found from the data that there is no fixed restriction or rule on the numbers of turn-taking and how much the amount of information is allowed to be conveyed by either party during the students-patient engagement. That means, the speakers here are found to interact the same as when they are outside the clinical setting – as turns are not strictly controlled by either party (Schegloff, 2007). Hence, any speaker has room to interrupt by giving new or further remarks, new topics and occupying turn at any 'transition relevance place' or TRP (turn occupied before the current speaker has completed his/her TCU – also an occurrence where the utterances are overlapped causing interruption (Sidnell, 2012).

From the data, the occurrences of interruption and overlapping speeches can be found the most with a talkative patient who is fluent in the common languages known by the provider – the students. Also, they are evident mostly during the solicitation of medical and dental information – history-taking phase despite the fact that interactions in this setting are transpired. This situation occurs regardless of task or relational talk.

In this particular setting, the student-operator is the active agent who should be managing the talk in pursuit to attaining the objective. However, the data also show one instance in which a patient influences the attending student-operator's management of talk which in turn, extends/triggers the time allotment given for the whole engagement. This is attributed by the patient's personality – overly talkative patient/extrovert patient and when the inexperienced students have less 'mastery' to interject the patient.

Hence, this section finds it crucial to represent two prototypical patterns of interactional management found in the UM Student's Dental Clinic data. The first example involves the students interacting with a talkative patient (where the patient is

found to occupy more turns and floors than the student-operator). The other engagement features the students and their 'taciturn' or 'reserved' patient where the student-operator is found to occupy more turns and acts as an initiator to the new topics of discussions. The arrangement of the section is divided according to the different attribute of the patient by looking into the CA particularities, residing under DA. The turn-taking is mainly scrutinized whereas interruption and overlaps are also discussed if they are found to transpire in the extracts shown. There are two subsections here that elaborate on these points:

- Management of talk involving talkative patients (Section 4.5.1.)
- Management of talk involving less talkative/ reserved patients (Section 4.5.2.)

### 4.5.1. Management of Talk Involving Talkative Patients

One out of ten engagements from the recordings features the students and a talkative patient. Such an attribute (talkative) is acknowledged by the students, especially the student-operator during the interview session when s/he mentions that the patient 'chats' a lot and eventually influences the flow of the dental progression. They are unable to proceed to Part 2 and make a presentation in front of the supervisor. The following Extract 4.26 is taken during the opening phase and the analysis intends to discover how these participants at this juncture manage their talk with one another:

Extract 4.26. High patient - involvement style through the representation of greater turn-takings when he introduces a new task and relational topics despite enacting humor/joke with the students

| | | |
|---|---|---|
| 1 | P1: | After ( . ) *sakit, I lari ah*: **SO1 is not present** [After pain, I run ah..] |
| 2 | SA1: | ha ha ha **Snickering** |
| 3 | P1: | *Boleh?* [Can?] |
| 4 | SA1: | *Tak boleh* [Cannot] ha ha ha **while snickering and shaking her head** |
| 5 | P1: | Aiyoooo: ……. **while gazing to his left side** |

| | | |
|---|---|---|
| 6 | SA1: | *Tak sakit . :* [Not painful...] |
| 7 | P1: | *Ya lah.* ↓ *cakap saje.* ↓ [Yea..I just say it..] |
| | | (0.7) |
| 8 | P1: | So how long would the whole thing take today err : Dr : Ai**** : You said 2 to 3 hours yah? ↑ **facing Dr. Aishah who just enters the cubicle and sits on the chair** |
| 9 | SO1: | Yeah ↑↓ normally, each session would take about 3 hours. |
| 10 | P1 : | [wow |
| | | ( . ) |
| 11 | SO1: | But if we can finish early : ↑↓ then : |
| 12 | P1: | Aaa: 3 hours that means, long: process wooh.. what you do to me? Can give uhh ( . ) G.A or not **stick tongue out** let me sleep. |
| 13 | SA1: | [ G. A ? |
| 14 | P1: | Yeah. Let me [sleep la, ya. just *tidur* [sleep] lah.. ( . )] |
| 15 | SO1: | [No : ↓ No : ↓ ( . ) ] |
| 16 | P1: | Then you do whatever you'll have to do lah: |
| 17 | SO1: | But we have to ask you questions… ↑↓ |
| 18 | P1: | Aiyoo : *sakittt* : ↑[Aiyoo, painnn] |
| 19 | SO1: | *Tanya soalan* ↑↓ *je tak sakit lahhh :* ↑↓ [ask question only, no pain lahhh] |
| 20 | P1: | *Sakitt :* ↑[pain] |
| | | **Serious face but joking** |
| | | **Both dental students snigger* |
| 21 | SO1: | Uhhh..Should I call you uncle? **while putting the gloves on** |
| 22 | P1: | = Eh don't la : [can ah no problem]. no problem **smiling* saya pun sudah 60*=[I'm already 60] |
| 23 | SO1: | [hmmm] **adjusting her hand gloves** |
| 24 | P1: | = senior citizen... [you respect] the (xxx). |
| 25 | SO1: | [uh hmm |
| 26 | P1: | = If you want to call me Mr. also I don't mind. How old are you? |
| 27 | SO1: | Aaah : Twenty : two |

28 P1: Very good. **pointing the SA** She?

29 SO1: Just the same

30 P1: So : How long ( . ) will all of you graduate? **while doing hand gestures**

31 SO1: Two more years.

32 P1: Wahh ↑ **claps**

33 P1: Dr. Afifah : She'd been tied down for 10 years. So now she's third year already ah. She got [7 more years].

34 SO1: [Ah I see : ] =

35 P1: = You know her? Your colleague. Afifah. She's the one who:

**SO1 and SA1 speak with each other about the 'mentioned' person. Though, their interaction here is not really clear**

36 P1: ( . ) You all local? From KL?

37 SO1: Uh : No. I'm from Kuantan.

38 P1: Huh very good. You come here, you escape the bow side. You? **pointing the SA1**

39 SA1: = I'm from Terengganu.

40 P1: *Terengganu? Wow la:gi best. cantik woo. The beach there, pantai. Sini westcoast ( . ) (shake his head) kotor la. Sana : pantai: putih ah?* [Terengganu? Wow more exciting, pretty woo. The beach there, beach.. here west coast is dirty. There white beach ah?]

41 SA1: Mhmm **nodding**

42 P1: *Sana:pantai sand ahh*? Quite sand *ah? Sini:* Here all are conta:minated by all :the vessels, all the way from the streets of Malacca. *Kotor sangat:* [There, the beach sand ah? Quite sand ah? Here, all are contaminated by all the vessels, all the way from Malacca. Very dirty.]

43 P1: **Turn his head gazing the D.O1**

44 P1: *Ni Syira, dia selalu ada ini macam ke interview ahh?* ↑= [This Syira, is she always having this practice? interview ahh]

45 SO1: = *Takk* [No] = first time = this is first time

46 P1: Woo. I very lucky ↑ **putting his hand on his left chest**. So I'm lucky. ↑

47 SO1: Yeah .hhh Lucky] ↑ ( . ) lucky ↑**grins**

48 SA1: [Heh heh heh first ↑

49 P1: *Ada (.) dia nak bayar saya?* [Is there any chance that she pays me?]

50 SO1: ↓ *Tak tahu la..* [I don't know]

51 ( . )

52 P1: *Belanja makan ke.. Nasi ayam [pun takda?]* *[Treat me food.. Chicken rice also don't have?]*

53 SO1: Tak tahu la,,. (grins) You ask her lahh]. [I don't know. You ask her lahh]

54 P1: Just kidding laaahh …. ↑↓ **grins and hand gesture indicating 'no'* Kita support...kita support...* ↑↓ ( . ) *Apa apa acara kita kena support kan...*while D.A1 ties an apron on this patient that covers his shoulder*. Untuk pertolongan semua semua* [Just kidding lah, We support, we support. Any events we have to support right. To help everyone]

**Dental students seem to double check everything and instantaneously start the session**

55 SO1: Mhmm.

(0.7)

56 SO1: So uncle: do you have any complaint or any pain?
= (mins 2.48)

57 P1: = After Afifah did? =

58 SO1: = Aha =

59 P1: = No.

60 SO1: No pain.

In this particular instance, the patient controls the interaction for a period of time making it difficult for the patients to reign control and to steer it back to task talk. The patient occupies the silence gap and holds the floor (lines 1 - 55). He also sometimes does not complete his TCU by proposing another new topic with the students as evident in line 35-36 when he changes the previous topic about his former doctor to asking about each the students' hometown. This extract is an instance of how the patient as opposed to the

students who largely makes an effort by opening ways to informality by self-selects and initiates a number of different relational practices and topics in his turns.

Additionally, the students do not interrupt nor switch into the main concern of meeting but they patiently and soothingly counter him with a self-deprecating disagreement and prolongations of syllables (line 15,17,19) followed by a half-suppressed laugh in later turns, and these show their deference to the client's talk. The student-operator also enacts the use of backchannel responses of "hmm, yes". The related examples as evidenced in lines 23 and 25 also indicate a sign of attentiveness to the patient's talk. A significant manifestation of interruption in which either party introduces a new topic or makes a new remark is not made obvious – except that the patient's utterances are overlapped with the operator's minor responses/backchannels like "aha, hmm" which signals nothing significant (e.g. indication of 'power') as they do not disrupt the topic. Thus, they are not regarded as an interruption but merely the display of relational rapport and continuation of interaction (James – Clarke, 1993 as cited in Cerny, 2010).

In line 55, the student-operator appears to utilize a non-lexical backchannel response '*Mhmm'* in line 56 as an implicit strategy to manage and 'cut' the talk by proceeding into the session footing to her institutional role. This situation occurs when she starts to manage the session into the history-taking session by asking the patient's complaint in line 56. There is high-patient involvement through greater turn-takings when he provides explicit explanation to a question posed. The overlapped and latched speeches also are evidently enacted between the student-operator and her patient.

The same patient is very engaged in his turns throughout the history-taking activity as shown in Extract 4.27.

Extract 4.27. History-Taking

| | | |
|---|---|---|
| 1 | SO1: | Uncle, when was your first notice the black tooth? 20 years ago or: = |
| 2 | P1: | = Uhh: This one or the one that Afifah did? = *his hand pointing the mentioned tooth* |
| 3 | SO1: | = No: [the: the one:] |
| 4 | P1: | [the black one ah?] |
| 5 | SO1: | *nods* [ha: the black one] |
| 6 | P1: | ohh ↑ [ma:ny years oh.] |
| 7 | SO1: | [many years ago] |
| 8 | P1: | I think easily five six years: ( . ) yeah five six years. But then I see the color starts to change, and become black woh. but this. no pain |
| | | *hands gestures indicating 'no'* |
| 9 | SO1: | No pain. |
| 10 | P1: | Not disturbing me. |
| 11 | SO1: | Just the color, just the = ***doing hand gestures while talking*** |
| 12 | P1: | = And then I said, why like that then I recalled back and say... I asked the dentist when they went and do my: ahhh: root canal. I see… what's wrong with the toothache... then she told me oh..nerve gone.. tooth crack, recommend to come here with those senior citizens. *But duit tak cukup* = [but not enough money] |
| 13 | SO1: | = Oh: *mahal*:= [oh. expensive] |
| 14 | P1: | = So *mari sini*: [come here] ah so come here: then he said basically u know why your tooth is taking black I said I did not know, and *dia tunjuk saya*. [he shows me] I said oh yah: how come ah, the whole this one because he did root canal I said yeah that's why it's getting black it's the big tooth..But.. |
| 15 | SO1: | [Yeah… |
| 16 | P1: | [Disturbing me? No it's not disturbing me. *Sekarang. pun. tua, siapa nak tengok?* [now old already.. who wants to see?] |
| 17 | SO1: | Hm |

18 P1: No. I'm just thinking: I don't know where to put the crown or that's all. *Lagi: ↑ saya ada satu implant sini.* [one more thing, I have one implant here]

19 SO1: [Implant:

20 P1: [Implant ____ hospital.

21 SO1: [aha:

22 P1: [Professor ravi. Uh..*Tak cantik. Dia sudah chip out. ( . )* [not pretty, it got chipped out]

23 SO1: [Ohhh:

24 P1: So, he asked me to go back. *I sudah buat satu appointment, tapi haritu sibuk I pergi satu outstation di Singapore.* [I've made an appointment, but i was busy that day in Singapore for outstation] *I sudah* postponed. So I make another appointment go and do. Uhhh:. the supplier: has given the warranty they: wi:ll replace the crown. =

25 SO1: =When?=

26 P1: =last year =

27 SO1: =last year =

28 P1: =I see ahh. Last year ah or: the year before that. ↑↓The implant here. ↑↓After you can see. *Sudah chip ada hitam sikit.* [done the chip then it has gone black a bit]

29 SO1: [Uhmmm. Ahh:

30 P1: [So the material also not good.

31 SO1: Er:The right: left?

32 P1: [Right. right.**pointing the mentioned tooth**

33 SO1: [right

34 P1: [ahh these are the molar side.

He provides explicit information in relation to presenting his concerns towards each medical or dental query posed by his student-operator (lines 12, 14, 18). A small instance

of overlapped speeches as opposed to interrupted speeches (since it does not disturb the topic discussed (James – Clarke, 1993)) is evident in line 4 when the patient takes turn at the TRP by helping the operator completing her doubt about the 'black tooth'. In this case, this could be a sign of responsiveness of each other's concern rather than something negative like the assertion of 'power' or 'dominance'.

Despite confining within a limited time allotment, the student-operator does not interrupt his verbose stories but courteously lends ear and signifies her attentiveness through both vocal - applying backchannel tokens (*'ohh' aha' 'uh hmm'*) indicating agreement, alignment or continuers and non-vocal conducts (occasional nods, smiles, gestures - line 15,21,23,29) in her turns while the stories are being presented. This suggests that she wants to maintain rapport, and does not want to appear rude or disrespectful.

The following extract illustrates the continuation of the previous extract when the participants mix relational talk within the task talk. This is as initiated by the student-operator when she (in her turns) self-selects and questions the patient about his familiarity with the technical word 'molar' in line 34, Extract 4.26 beforehand. In Extract 4.28, the participants overlap and latch their speeches when engaging in a relational talk revolving around task concern. This is also an example on the hybridity of relational talk within task talk.



Extract 4.28. History-Taking

| | | |
|---|---|---|
| 1 | SO1: | Woahh: ↑ uncle ↑ you know all the molar?? |
| 2 | P1: | These **pointing the position of molar teeth on the right side** molar.. |
| 3 | SO1: | **students are amazed** wohhhh: ↑ |
| 4 | SO1: | [Incisor? |

5 P1: [Incisor↑

6 SO1: Woahh ↑ *amazed* *snicker* Woah uncle ↑

7 P1: *Mestilah:* ↓ *Kita ada sekolah:* ↓ [of course.. we have/go to school]

*SO1 conveys information to SA1*

*after 0.6 seconds*

8 P1: *Itu yang chewing. apa nama? Chewing the tooth. canine?* [that one 'chewing' what is it called?]

9 SO1: Uh: the bratcism

10 P1: No. the teeth. Ah *itu* canine teeth? **pointing the teeth**. *Itu yang*: the two sharp one. [No, the teeth. ah that canine teeth? that.. the two sharp one]

11 SO1: = Oh canine? =

12 P1: = Ha see =

13 SO1: = *Taring.* =[canine]

14 P1: = *Itu canine kan. Ada ingat lagi:* [That is canine right. Still remember]

15 SO1: *Haaa uncle you belajar bila: ? ↑ Macam mana uncle tau?*= [When did you learn Uncle? How do you know?]

16 P1: *=Eh kita ada sekolah:* ↓ *kita belajar ini* ↓[eh we have school.. we learn this..]

17 SA1: **snicker* [Kitorang kat sekolah tak belajar:* [we didn't learn this at school]

18 SO1: *[Kitorang kat sekolah tak tau pun* [we didn't know this when we're at school] **snicker**

19 SA1: *[kitorang kat sini baru tau* [we only got to know when we're here]

20 P1: *Kita dulu itu* Cambridge. [it was Cambridge back then]

21 SA1 & SO1: [ohhhh:

22 P1: *[Kita dulu ada exam. Macam ini spantal, temporal, kita semua tau:* [We had exams. Like this spantal temporal all we know]

23 SO1: *Woah! Uncle, so boleh guna lah medical terms lah dengan uncle?* [Woah! Uncle, so, can use medical terms with uncle]

24 P1: *Sikit sikit lah: itu lumbar: cervicle: .alfo alfai c1 c2..*[just a little bit lah. That lumbar, cervicle, alfo alfai c1 c2]

25 SO1 & SA1: [Woah: ↑ohh

26 P1: [*kita tau: cervicle kan ini kita punya bone kan?]* [We know.. cervicle is our bone right]

27 SO1: [Ha:

28 P1: *[Ya semua ada..Lagi koksi..Yang last skali .. bole laa tipu tipu sikit bole la.Jantung pun saya tau.* *[Yes all have. Another is koksi, the last one, can laa lie a little bit can la. Heart also I know]*

29

*Both students snicker*
*SO1 conveys information to SA1*
*(after 0.9 seconds)*

30 P1: Ya. *Nanti* [later] u can see afterwards Dr. Aishah. Ai:shah right?

31 SO1: Ahh. Just don't call me doctor: ↓im not a doctor yet:↓ =

32 P1: =No. No. I must respect, I must respect: ↓ Dr. Aishah.. then must give you motivation lah: *Inspirasi la: Betul?* [Inspiration laa.. Right]

33 SO1: **little laugh** Yes

34 P1: *Kalau tak alamak uncle ni tak hormat* ( . ) *Ni doctor pun kan?* Nur? N.O.R [if not alamak this uncle does not respect. she is doctor too right?]

*pointing to SA1*

35 SA1: N. U. R ****spell out name****

36 P1: N.U.R – NUR =

37 SO1: D.O1: = *Uncle, bila chip off tu: bila uncle notice, kena chip off* = [uncle, when chip off.. when uncle notices this has got to chip off]

38 P1: = Wohh. [One week after *dia buat implant wohh* [one week after he did the implant]

From lines 1-36, the participants engage in a small relational talk with one another when the students show surprise with patient's familiarity of the technical words in dentistry. They latch their utterances with one another (lines 11-16). They also overlap utterances (exchanges of turns in lines 17-28) which suggest their anticipation and the feeling of excitement and strengthening of their relational rapport. The last turn for such a topic ends in line 28 when the student-operator focuses on the work by conveying relevant information to the student-assistant. The next small talk emerges about address form where the student-operator raises that she does not want to be called a 'doctor' as she is

not yet one (line 31). The focus to instrumental or task concern is gained back in line 70 when the student-operator manages the turn and latches the patient's previous 'spelling' by taking turn and asking a question pertaining to the patient's tooth.

From the data as a whole and in comparison with the other engagements observed, these participants take longer time during the history-taking phase. Correspondingly, the management of talk in their later interactions is a similar manifestation of the examples and analysis provided above. In particular, relational talks are seen embedded, often initiated by the patient when he senses a silence gap in between the session. The patient is responsive by often latching or overlapping his utterance with the previous speaker's utterance. In accord with the verbose utterances raised by the patient, minor responses are then given by the operator in the alternating turns. To cut the verbose or long interactions transpired during this phase, the following is the extract taken during the last part of history-taking phase when the participants passage their route into the examination phase. Extract 4.29 features a single turn-taking occupied by participants from the last few utterances in history-taking to examinations.

Extract 4.29. History-taking to Intra and Extraoral Examinations

| | | |
|---|---|---|
| 1 | SO1: | *Uncle. Uh: anak anak uncle eh takda masalah eh* [Uncle, your children do not have any problem eh?] |
| 2 | P1: | **shake head indicating no** |
| 3 | SO1: | *Uncle boleh tak masukkan 3 jari mcm ni? Ha:* [Uncle can you insert your three fingers like this? Ha] |
| 4 | SO1: | Ok. |
| | | ( . ) |
| 5 | P1: | *First time woo. Ni untuk apa?* [What is this for?] |

6 SO1: *Ni untuk: check temporal.* [This is for.. checking temporal]

7 SA1: *Nanti angin kat sini *pointing ears**

**doing examination on patient's head**

8 P1: *First time I try ini.* [first time I try this]

9 SO1: *Sebab sometimes ada orang tak boleh masuk:* [Because sometimes there are people who can't do this – insert three fingers]

10 P1: *Yaka?* [is it?]

11 SO1: *Itu sebab block* [That's why it blocks]

12 SO1: *Ha. Macam nak check uncle ada problem kat sini ke: kat sini kee:* [Ha. To see if uncle has problem here, or here] **pointing parts of head and neck**

Extract 4.29 shows an instance between the participants who are passaging their route into the intraoral and extraoral examinations phases. Each participant takes turn at the end of each current speaker's end of TCU. In line 5 after the short silence gap, the patient self-selects by asking the student-operator regarding the purpose of inserting three fingers inside his mouth. The student-operator in her later turns occupies her floor by clarifying the purpose. The patient later responds and gives a remark that he has never done so before (line 9). The student-operator further clarifies to his concern and later continues doing examination on his head before seeking consent from him to check on his mouth. When the intra oral examination starts, interaction is only found apparent between the student-operator and her student-assistant for the information coding purposes. Additionally, this patient is the only client who enquires the student-operator about the need to perform such an extra oral examination.

Despite the huge amount of information provided by the patient, there is no evidence showing that the student-operator interrupting his patient's talk (whether his talk are relevant or not). This is in actuality seems to be her major challenge in the

workplace as discovered from the interview session when she confesses about not knowing how to interrupt or 'cut' her client's talk, but having to maintain respect (by politely attending to him/her), as this is one of the factors affecting or influencing his/her satisfaction with the overall dental care. Above all, the closing phase for this engagement is not evident from the recordings – could be due to unexpected technical failures.

### 4.5.2. Management of Talk Involving Less Talkative/Reserved Patients

The previous engagement however is a different scenario with the following – when the student-operator deals with more reserved patients. Being with such a patient, the student-operator is the one who does the self-selection of turns by opening new topics, asking new questions or making clarifications. This in turn adds into an advantage – ability to complete the dental work on time.

Extract 4.30 features linear turn-taking where participants take turn after completing their TCU.

Extract 4.30. Opening

| | | |
|---|---|---|
| 1 | SO4: | *So harini sihat: Mr. *** sihat?* [So, today feeling healthy, Mr.. you're feeling good?] |
| 2 | P4: | Sorry:? |
| 3 | SO4: | *You sihat?* [Do you feel good?] |
| 4 | P4: | *Sihat sihat:* [Yeah I feel good] |
| 5 | SO4: | *Dah breakfast dah?* [Have you taken your breakfast?] |
| 6 | P4: | *Dah dah.* [Yup, I have] |
| 7 | SO4: | *Because harini: I akan just uhh: tanya you history semua untuk data: then: for another treatment then start with the treatment lah. For today no treatment lah eh, just to collect your data.* [Because today, we will go through history-taking for data |

collection purposes, then we will start with the treatment. Oh for today, there would be no treatment, just to collect data]

8 P4: *nod*

9 SO4: So Mr. ***, do you: have any complaint for your oral health?

10 P4: Not at the moment. *Terlampau banyak* [There's just too many] ha ha ha

This type of engagement also is analyzed based on the overall accessibility of the data, starting from the opening phase until the end of recordings. All extracts shown in this section depict the situation where the student-operator who initiates the talk or questions. Meanwhile, the patient takes turn after the operator has completed each TCU.

The above utterances are the first lines captured by the recordings. It is discernible from the above extract that the student-operator self-selects by enquiring the patient on his well-being and asking him whether he has taken his breakfast (lines 1-6). Without any discernible presence of (slight) pauses or any other new relational topic or small talk being latched onto by either party, they smoothly move into the history-taking phase when the operator in line 7 again occupies the floor and takes turn by clarifying the patient about what would be done throughout the session. The following extracts show the rest of the interactions with the same reserved patient:

Extract 4.31. History-Taking

1 SO4: So: for today's concern: Just for regular check up?

2 P4: Ok: yes.ok: *nod*

3 SO4: No pain: *hand gestures*

4 P4: No.

5 SO4: So when was your last dental check up?

6 P4: Emm: I think about two to three months ago, got my tooth extract

7 SO4: Extract? Here?

8 P4: Ah noo. In a: *thinking* ss14

From the above extract, the student-operator and patient smoothly takes turn after each has completed his or her TCU. This is dissimilar to the management of interaction with that of the previous engagement where the patient mostly at various phases occupies more turns by being verbose and either latching or overlapping his utterances with that to his student-operator's minimal, 'acknowledging' response in relation to each question posed to him - leaving almost no room for the operator to take turn and proceed with other significant queries within the best duration of time. Here, the operator in lines 1,3,5,7 above initiates a question within the alternating turns and the patient briefly responds to each of the query - also suggesting the harmonious and smooth management of talk. This is similar occurrence and manifestation in their following interactional engagement at this phase:

Extract 4.32. History-Taking

| | | |
|---|---|---|
| 1 | SO4: | Private clinic? |
| 2 | P4: | **nod** private private |
| 3 | SO4: | So three months= |
| 4 | P4: | = Three months ago. I think about January **nod** |
| 5 | SO4: | You done extraction? |
| 6 | P4: | Sorry? |
| 7 | SO4: | You done extraction? on that day.. |
| 8 | P4: | **nod** |
| 9 | SO4: | So yeah anything complication like bleeding for a long time? |
| 10 | P4: | No no: I think the bleeding was normal and about an hour, I remove: yeah.. |

There is no interjection of relational talk within this phase by these participants that they smoothly take turn at the end of each utterance (TCU) by the previous speaker. The

similar pattern of interaction in which the student-operator asks and the patient answers (both are very brief and direct) ensues until the student-operator starts with extra oral examination, followed by intra oral examination. Afterwards, the supervisor comes in and does the dental checking on the patient. The gained data stops at the jaws and dental checking where only minor interactions by the student-operator is transpired – when s/he instructs the patient to (first) insert his three fingers after completing the history-taking session. This can be seen in the extract taken from the last lines of history-taking as follows:

Extract 4.33. History-Taking to Intra and Extraoral Examinations

| | | |
|---|---|---|
| 1 | SO4: | Do you take chewy? That green leaves and then we always chew |
| 2 | P4: | No |
| 3 | SO4: | Do you have habit like: grinding your tooth drink |
| 4 | P4: | No |
| 5 | SO4: | Or biting pencils: pen. or nails? |
| 6 | P4: | No. |
| 7 | SO4: | Ok for the diet, do you usually take more sugar drinks..or sugar food.. |
| 8 | P4: | No no.. |
| 9 | P4: | No I don't, I drink black coffee with less sugar or without sugar, either one only. |
| 10 | SO4: | So can you do three fingers *D.O4 demonstrates* in your mouth..? |
| 11 | P4: | *Follows D.O4*.. Like this.. |
| 12 | SO4: | Ok like that: |

Line 1 – 9 is the same management of talk between the active participants where they smoothly take turn by enquiring or responding at each speaker's completed TCU prior to steering into the examinations phase. These activities are further elaborated in the next section.

## 4.6. Communicative Activities and Manifestations in Task Talk

As frequently mentioned throughout this study, task talk aims to primarily accomplish the basic purpose of the dental meeting – to address the patient's oral health problem. Crucially, and by looking at the general completion of 'EnD' (of Part 1 and 2), the student-operator needs to accomplish the objectives through 'talk' with the patient apart from the dental examinations alone.

To achieve this, s/he needs to enact task talk with his/her patient and assistant (crucially) during these following 'task' phases; i) history-taking, ii) physical examination on the patient's head, jaw/neck and mouth and iii) oral health education (Part 2). Since the recordings lack the data on 'oral health education' (where the operator educates the patient on the particularities pertaining to brushing teeth and its other related components), hence, this section only analyzes the communicative activities transpired during the first two aforementioned phases, under the following subsections but excluding the talk between the student-operator and student-assistant:

- Question-and-answer types during history-taking (Section 4.6.1)
- Speech acts during physical examinations (extraoral and intraoral) (Section 4.6.2)

### 4.6.1. Question-and-Answer Types during History-Taking

In relation to this context, taking history from a patient is a crucial part of dental diagnosis and also a basis to the doctor-patient relationship (Stoeckle & Billings, 1977; Drew, Stoeckle & Billings, 1983) that is equally regarded as basic communicative activities or

speech acts of questioning performed by the dentist - in this case the student-operator - and answering by the patient. Here, the student-operator who is in the phase of doing formal interrogation does not merely question the patient but s/he also alternately transfers the information gained from the patient to his/her student-assistant to be coded in the computer (but as mentioned, the analysis focuses on the interaction between the students with the patient only). The following are the general constituents discussed during patient's history:

- Chief complaint
- History of present illness
- Past dental history
- Past medical history
- Family history
- Social history

History-taking is one of the significant procedures of oral diagnosis as it also allows scrutiny of the patient's symptoms, apart from the physical examinations (Chandra, Amitabh & Douglas, 2007). To achieve this, the student-operators who base the questions following the relatively standardized list of questions or what Cassel (1985, p.89) puts it as "a fixed measuring instrument" should probe as much information from the patient as quickly and proficiently as possible (Waitzkin, 1991 as cited in Boyd & Heritage, 2006).

According to Boyd and Heritage (2006), some basic preliminaries suggest that the questions posed by the student-operators include the following features: 1) the operator starts with establishing a topic or agenda in its equivalent and move to another agenda for patient response; 2) they employ the 'preference' questioning type like close/open ended questions that demand or favor one type of answer or narrative type of answer and 3) they

also make presuppositions on a lot of aspects about the patient's lifestyle or medical and dental information.

Likewise, they also mention that the patients devise responses in ways that agrees or disagrees to any or all of these features mentioned. They also align or disalign to the "preferences" questioning type employed by the student-operator and/or confirm or disconfirm the presuppositions made through the question posed by the student-operators. Above all, it is also believed that the type of responses given by the patients as laymen may also be influenced by the social variables: their social, cultural background or attributes (Pierret, 2003; Schouten & Meeuwesen, 2006) – as evident from the ethnographic observation and interview session.

Instead of just focusing on the student-operators, the present analysis also finds it crucial to look into the answer types by the patients because the question-type by the student-operator is also influenced by the recipient's design despite the fact that interaction is a joined social action produced by the interlocutors involved (Sidnell, 2010; Hudak & Maynard, 2011). Thus, this section discusses the following particularities in relation to the question-and-answer designed by both active agents at this phase: the student-operator and the patient. Ideas are drawn from the aforementioned theoretical framework set by the same authors (Boyd & Heritage, 2006):

- The participants engage or disengage in the topical agenda
- The patient aligns and disaligns to the 'preference' questioning type posed by the operator
- The patient confirms or disconfirms the questioning type embodying presupposition employed by the student-operator via the discourse particle *"kan"*[right]

### a. The participants engage or disengage in the topical agenda

Boyd and Heritage (2006) propose that questioning consists of two elements. First, the different concerns or issues formulated through questions are equated to setting the different topical agendas. For instance, the student-operator may start with past medical queries as subsuming one topical agenda before shifting to past dental queries as the second the topical agenda. The following is an example:

Extract 4.34. Malay female operator and Chinese male patient

| | | |
|---|---|---|
| 1 | SO4: | **Trauma? Do you have any orthotherapist?** |
| 2 | P4: | No. I actually: quite cautious about (xxxxx) |
| 3 | SO4: | Do you bring with you: the green card right? |
| 4 | P4: | Green card: no. |
| 5 | SO4: | **So your last denture was on January.** |
| 6 | P4: | Yes January. |
| 7 | SO4: | January. |
| 8 | SO4: | Have you done scaling before? |
| 9 | P4: | Long time ago |

In this extract, the student-operator sets two topical agendas by first querying about the particularities related to the patient's past medical history - the first topical agenda (lines 1-4) prior to shifting into the dental queries, the second topical agenda as evident in line 5-9. The third or fourth topical agendas may also appear if the next questions are formed in relation to bringing up other concerns pertaining to e.g. patient's lifestyle and family background. From the data, the patients are found to engage in a topical agenda under discussion by responding to the questions set by the student-operator and none disengages by rejecting to answer. More on the question-answer types by participants are elucidated in the next section.

**b. The patient aligns and disaligns to the 'preference' questioning type posed by the student-operator**

The present data show that the student-operators mostly employ close-ended questions that demand a specific answer of "yes/no" from the patient. This question type is also found to occasionally reverse by the student-operator realized through the polarity item of 'any/ever' at the beginning of a question e.g. "Any asthma/allergy?". As Boyd and Heritage (2006, p.160) claim, the "default preference is that the recipient should align to affirmatively framed Yes/No questions with "yes" and to negatively framed questions with "no".

Remarkably, with a reserved patient, such type of a question is received with the favored answer of yes/no or by doing facial gesture signaling yes/no as the first component of a response. Additionally, if the response is 'yes', a further remark about it is only given in another turn by the patient when the student-operator probes further on the similar matter under discussion in the next turn. This is possibly done in assuring the accuracy of the diagnosis.

Meanwhile, it is a different practice with the talkative patient. For example, if the close-ended question by the student-operator is received with an affirmative response "yes", then the additional information or further remark is also stated by the patient in the same first component of turn. This is however, not in accord with the aforementioned statement proposed by Maynard and Heritage (n.d.) who posit that the default preference is when the recipient should align by answering either "yes" or "no" to the close-ended-type-of-question posed. Above all, this is in actuality not to portray the accurate or inaccurate way of practice but merely to document the interactional practice, specifically the question-answer-type employed by the active agents involved at this phase. An example of the former can be seen in the following extract:

Extract 4.35. Malay female student-operator and Chinese female patient

1 SO3: *Uh: cuci gigi pernah tak sebelum ni?* ↑↓***Pernah cuci gigi tak?*** [uh... have you done scaling before? **Have done scaling or not?**]

2 P3: ***Tak pernah.*** [**have not done/never**]

3 SO3: *Lepas tu:* ***you pernah*** ↑↓ ***tak tampal gigi sebelum ni?*** [and then... **have you done filling before this?**]

4 P3: ***Pernah*** [**I have**]

5 SO3: ***Ingat tak last time bila? Ke dah lama?*** [can you recall when was the last time you did that? Or was it done long time ago?]

6 P3: ***Dah lama la:*** [long time already]

Here, the patient aligns to the close-ended question type employed by the student-operator when the student-operator asks whether the patient has done 'scaling' and 'filling' in line 1 and 3 by responding either yes/no, or in this sense - "have or have not". The student-operator then shifts to a new question after receiving a negative response "have not" – type of answer which is a preferred or an aligned response to her polarity preference expressed in the question particularly when she employs the tag question "*Pernah tak?* [Have you]" (line 1 and 2).

Interestingly, the student-operator within the same topical agenda on past dental information is keen to know more about the question raised when the patient answers "I have". This can be seen in line 3 when the student-operator further asks the patient whether she has undergone filling. Similarly, the patient aligns the answer by affirmatively responding "I have" in her subsequent turn. Any further remark is not evident after uttering "I have" by the patient in the next turn. The same topic continues when the student-operator in her turn (line 5) probes further about "when was it done" and the patient provides answer by uttering *"dah lama la"* [long time already]. No narrative

is present but a brief, simple fashion, and preferred answer aligned to each question-type employed by the student-operator.

The same manifestation or practice is found in the following extract when another student-operator also employs the close-ended question-type in soliciting the patient's past medical information; except that the answer given by the patient in each turn is relatively different when she answers *"takde"* [no/nope/ "don't have"] – another local variant Malay word available to assert a negative response to the question posed:

Extract 4.36. Chinese female student-operator and Indian female patient

| | | |
|---|---|---|
| 1 | SO2: | ***Puan ada darah tinggi kan? Puan pernah tak jatuh?*** = [You have blood pressure right madam? Have you ever fallen down?] |
| 2 | P2: | **= *Takda.=*** [nope] |
| 3 | SO2: | **= *Lepas tu ada sakit jantung ke?*** = [And then do you have a heart disease?] |
| 4 | P2: | ****head indicating no**** |
| 5 | SO2: | = *Takda eh: Then ada tak masalah paru paru?=* [So it's a no... then do you have a liver disease?] |
| 6 | P2: | = *Takde =* [nope] |
| 7 | SO2: | = *Then ada masalah berkaitan dengan tulang? Macam pernah buat simen?=* [Then do you have problems with bones? Like have you ever got cemented] |
| 8 | P2: | ****head indicating no**** |
| 9 | SO2: | = *Lepas tu ada tak masalah dalam perut? Macam gastric?* = [And then have you had any problem with stomach? Like gastric..] |
| 10 | P2: | ****head indicating no**** |

The patient in the extract above also aligns to the preference questioning type by the student-operator; close-ended of yes/no questions when she affirmatively frames it by responding *"takda"* [no] (line 2) or by showing facial gesture that structurally favors to a 'no' answer in response to the questions raised by the student-operator in lines 4, 8, 12.

Similar with the previous extract, the student-operator shifts to a new close-ended question after receiving a 'no' type of answer (regardless of the utterance of facial gesture from the patient) as opposed to probing or exaggerating about the same question after the negative response by the patient in the pursuit of further validating on the authenticity of the 'no' response signaled by the patient.

These two earlier extracts that show how each student-operator employs close-ended questions and the patient's alignment to the questioning type however, is a dissimilar illustration with the patient in the following Extract 4.37 and 4.38:

Extract 4.37. Malay female operator and Chinese male patient

| | | |
|---|---|---|
| 1 | SO1: | Apart from Nexium, **do you take any medication?** |
| 2 | P1: | **Yes. I take: lipanthyl: 145. that's for my uhh: gasteroid 3g 3g. hyper.** |
| 3 | SO1: | Oh: |
| 4 | P1: | **3gi tu [the 3gi]: cholesterol la. blood la.** |

In line 1, the student-operator employs a close-ended question and this is received with an affirmative response "yes" accompanied with continuous, specific remarks made by the patient about his medication in the same turn, line 2 – supposing that the information is necessitated by the student-operator without having to wait until she enquires. This is different with the illustration/example in Extract 35 when the student-operator in her next turn has to probe further about the matter under discussion after an affirmative response "yes" is vocalized by the patient in her single turn. The next example is another extract taken involving the same participants in the present Extract 4.37:

Extract 4.38. Malay female student-operator and Chinese male patient

| | | |
|---|---|---|
| 1 | SO1: | **Uncle, when was your first notice the black tooth? 20 years ago or:=** |
| 2 | P1: | = Uhh: This one or the one that Afifah did? = **his hand pointing the mentioned tooth** |
| 3 | SO1: | = No: [the: the one:] |
| 4 | P1: | : [the black one ah?] |
| 5 | SO1: | ****nods**** [ha: the black one] |
| 6 | P1: | ohh ↑ [ma:ny years oh.] |
| 7 | SO1: | [many years ago] |
| 8 | P1: | **I think easily five six years: ( . ) yeah five six years. But then I see the color starts to change, and become black woh. but this. No pain** **hands gestures indicating 'no'** |
| 9 | SO1: | No pain.= |
| 10 | P1: | = Not disturbing me.= |
| 11 | SO1: | = Just the color, just the = **doing hand gestures while talking** |
| 12 | P1: | **= And then I said, why like that then I recalled back and say... I asked the dentist when they went and do my: ahhh: root canal. I see: what's wrong with the toothache... then she told me oh: nerve gone: tooth crack,recommend to come here with those senior citizens. *But duit tak cukup* =** **[but not enough money]** |
| 13 | SO1: | = Oh: *mahal*:= [oh. expensive] |
| 14 | P1: | = So *mari sini* [come here]: ah so come here: then he said basically u know why your tooth is taking black I said I did not know, and *dia tunjuk saya* [he shows me]. I said oh yah: how come ah, the whole this one because he did root canal I said yeah that's why it's getting black it's the big [tooth: But: |
| 15 | SO1: | [Yeah… |
| 16 | P1: | [Disturbing me? No it's not disturbing me. *Sekarang pun tua, siapa nak tengok?* [now old already, who wants to see?] |

The same participants engage in another topical agenda about the patient's past dental information – specifically about black tooth and the utmost attention for the above extract should be given to lines 8-16. The utterances at line 8 that stops until "five six years"

should be the preferred or sufficient answer in alignment to the question raised by the student-operator in line 1 when she first asks about "when does the patient notice about the black tooth". However, the patient sees "when" as an opportunity to begin a narrative about his black tooth. Interestingly, the narrative is further digressed as evident in lines 12 and 14 and it is not disrupted by the student-operator but being acknowledged when she attentively listens and latches them with a minor response like "oh, yeah". This is a dissimilar practice when the same question on "when/do you remember when?" by the student-operator in Extract 4.35, line 5. is received with a minor response by the patient "*dah lama la"* [long time already].

Also interestingly, the patient in line 16 anticipates or presupposes about the relevant question that might be posed to him (on whether the black tooth disturbs him or his appearance) by structuring this presupposition in forming his own close-ended question about his black tooth; "disturb me?" and right away providing the answer "no it's not disturbing me". He also digresses the previous "no" answer by commenting that he is already old that no one would bother seeing him and his tooth/teeth.

**c. The patient confirms or disconfirms the questioning type embodying presupposition employed by the student-operator via the discourse particle *"kan"*[right]**

Some of the student-operators' questions also embody presupposition for example when the student-operator in line 1 below shapes the supposed close-ended question into "*Uncle tak ambik alcohol **kan**. uncle just smoke"* [you don't consume alcohol **right**, you just smoke]. This questioning type that favors confirming response or prefers a 'yes' response; realized mainly through the use of a polarity item "*kan* [right]". It presupposes that as if the student-operator has already known his patient up to the fact about him never consuming alcohol but just smoking cigarettes in his entire life. However, she is yet to

make a confirmation upon each presupposition made, hence, embodying them each in such a questioning type as in the following extract.

Extract 4.39. Malay female student-operator and Chinese male patient

| | | |
|---|---|---|
| 1 | SO1: | ***Uncle tak ambik alcohol kan. uncle just smoke.*** [uncle does not consume alcohol right, uncle just smoke] |
| 2 | P1: | *23 24 tahun.* [23 24 years] |
| 3 | SO1: | *Rokok:* [cigarrates] |
| 4 | P1: | *Rokok: sudah berhenti. Sudah berhenti*.[cigarettes, have stopped, have stopped] |
| 5 | SO1: | [stopsmoking |
| 6 | P1: | [stop smoking 19. 1992 |
| 7 | SO1: | Alcohol no. alcohol no ah? |
| 8 | P1: | No no |

As the patient responds in line 4, he first disconfirms the presupposition made by saying that he has stopped smoking and later, precisely mentions the age and year when he stops smoking that is, when he was 19 years old and in 1992. This remark is overlapped with the student-operator's utterances when she repeats the confirmation made about "stop smoking" in line 5 (an act of confirming, in response to the remark made by the patient in the previous turn, line 4).

Meanwhile, the negative response 'no' is later provided by the patient regarding the presupposition made about him for not consuming alcohol after the query is resumed again by the student-operator in line 7 "alcohol no ah?". It can also be considered as an act performed by the student-operator in confirming about her patient's non-consumption of alcohol. The same trait can be seen in the following extract:

Extract 4.40. Malay female student-operator and Chinese female patient

| | | |
|---|---|---|
| 1 | SO3: | ***Then kalau:*** **last time you** ***datang*** **dental check up*****: Dekat sini kan?*** [Then if..Last time you went for the dental check up here right?] |
| 2 | P3: | Aha: |
| 3 | SO3: | Last time? *Bila? Bulan lepas?* [When? Last month?] |
| 4 | P3: | *Ha: bulan lepas:* [Ha, last month] |

By having some prior knowledge about the patient's visit in the clinic, the student-operator in line 1 of the above extract is found to frame her question that embodies presupposition, realized through the discourse particle *"kan"* [right?] at the end of the question – this is pertaining to the patient's last visit in the same dental clinic. This is however confirmed when the patient gives a minor response *"aha"* which is structurally parallel to 'yes' answer in her turn.

### 4.6.2. Speech Acts during Physical Examination

Apart from the history-taking, physical examination is another crucial 'task' phase that assists the dentists into the interpretation of a patient's oral diagnosis (Chandra & Chandra, 2007). However, Clealand et al. (2013) have found out that the manifestation of talk amongst the participants involved at this phase is understudied. As mentioned in Section 2.4.5, these authors fill the research gap and their findings show that the students' talk at this phase fall into four categories (i) reducing talk ii) applying positive evaluative talk iii) repeating the patient and iv) expressing intention and/or seeking consent.

The present data correspond with the first finding on the first category labeled as 'reducing talk'. This is very much discernible from the present data when there is only a very little of verbal enactment/interaction transpired – either between the student-operator and his/her patient or from the student-operator himself/herself. Therefore, the section is

keen to shift focus by examining the available speech acts employed by the student-operator who occupies the professional role when interaction is relatively minimal regardless during extraoral or intraoral examination. The interpretation of analysis is further injected with the aforementioned findings gained by Clealand et al. (2013) - if any occurrence in the present data is found to be in accordance with them.

By focusing on speech acts, this is also in simultaneity to see how the dental students (student-operators, though novices) construct their professional identity at this phase clutching the role as a dentist who is yet to perform an oral examination on the patient's mouth. As Stubbs (1983) postulates, speech acts and social roles are greatly connected and the student-operator as the active healthcare provider in this context intensely are accountable for their patient's well-being and feelings. This can be enacted or realized through particular speech acts they normally use during patient's engagement. The evident speech acts manifested by the student-operator to the patient at this phase are directing, questioning and stating/informing.

**a. Directing**

Directing, whether expressed in a direct or indirect manner is the speech act used in an attempt to get the listener or other interlocutor to perform an action (Searle 1969; Yule, 1996). In the context of doing physical examination, the student-operator mainly or 'gently' directs the patient to open or close his mouth, to bend head (during extraoral examination) and others after stating that he/she wants to perform an examination on the patient. Extract 4.41 and Extract 4.42 below illustrate the occurrence where the patient directs the patient to perform such actions:

Extract 4.41. Directive speech act

**1 SO3:** ***OK: I nak rasa you punya jaws dekat sini: bukak mulut: close:.bukak: close:.tunduk: tak tak ni tunduk: ke kiri:*** **[Ok.I want to feel your jaw here. Open your mouth, close, open, close, bend your head, to the left:]**

**2 P3:** **following the instructions**

The bolded phrases above are the instances of directive speech acts performed by the student-operator to the patient during jaw examination. The patient at the same time carries out the particular actions directed/requested by the student-operator. The same activity is also evident in the next extract:

Extract 4.42. Directive speech act

1 SO7: *Saya nak check sini.* [I want to check here – this part]
**pointing his jaw and patient follows**

****SO7 gets ready for the checking session and later comes back to the patient for the jaw exam****

2 SO7: ***Nganga: Tutup: Nganga: Tutup:*** [Open mouth, close, open, close]

3 P3: **following the instructions**

However, the following utterance in line 1 illustrates the example of an indirect directive speech act though there is a use of a marker "*eh"* by the student-operator in softening or minimizing the utterance when s/he seeks to perform an examination on his/her patient's mouth. This may also at first suggest or resemble the 'stating' or 'questioning' speech act for many when it is mainly not. This statement however receives a slight misunderstanding on the patient's side when s/he initiates the trouble "*apa tu?* [what's that?]" and this is resolved when the repair is fixed by the student-operator in line 3 who

states back on the intended activity s/he seeks to undergo with his/her patient (that is, to perform the dental examination).

Extract 4.43. Directive speech act

| | | |
|---|---|---|
| 1 | SO1: | ***Uncle: nak check dalam mulut eh:*** [I want to perform examination/checking inside your mouth okay uncle] |
| 2 | P1: | *Apa tu?* [what's that?] |
| 3 | SO1: | ***Check*** ↓↑ ***dalam mulut:*** [checking inside your mouth] |

From these instances, the students-operators express their intention through the use of directive speech act, regardless in a direct or indirect manner.

## b. Questioning

Questioning is simply defined as the act of asking (Searle, 1969). The following extracts illustrate the presence of this apparent speech act (of different concerns) during head, jaw, neck and mouth examination performed by the student-operator to the patient before they passage their way into the oral examination session:

Extract 4.44. Questioning speech act

| | | |
|---|---|---|
| 1 | SO1: | ***Sakit tak?*** [did it hurt?] |
| 2 | P1: | *Tak.* [No] |

The speech act of questioning; close-ended type "did it hurt?" in line 1 above where the student-operator asks the patient about his current state of feeling due to undergoing examination depicts an expression of the student-operator's tenderness, caring and concern towards her patient's health being. This particular speech act of questioning "was it hurt?" used by other student-operator is also evident in Extract 4.45, line 1 as follows:

Extract 4.45. Questioning speech act

1 SO3: ***Sakit tak tadi?*** *[did it hurt?]*

2 P3: *Tak.* [No]

3 SO3: ***Tak eh:*** **[No yeah]**

Extract 4.44 and 4.45 clearly reveal the instances of the student-operators' evaluative talk when they check about their patient's state of being by uttering "*sakit tak?* [did it hurt?] through the use of questioning speech act. Line 3 as well depicts the same speech act when the operator repeats the patient's utterance "*tak eh"* [no yeah] but it does not necessitate an answer from the patient – she is just merely repeating the patient's remark "no yeah" (line 2) through the speech of questioning (Clealand et al., 2013).

Another concern under this speech act is when the student-operator questions the patient (mainly realized through the modal verb (can) and reference (you) and high rising mark (?)) to place his/her fingers inside the mouth as in line 1, Extract 4.46 below:

Extract 4.46. Questioning speech act

1 SO4: **So can you do three fingers in your mouth? in your mouth?**

**SO4 makes a demonstration**

2 SO4: **Following the demonstration** Like this:

3 SO4: Ok like that.

Besides questioning, the student-operator also manifests the speech act of 'clarifying'/'stating'/ 'informing' and this is elucidated in the next bullet point:

### c. Stating/Informing

Stating which is interchangeable with informing is the act of expressing something to the addresses or "committing a speaker to the truth of an expressed proposition" that falls under 'representatives' speech act as its bigger term (Searle, 1969). The following extracts show how the operator performs this particular speech act to the attending patient:

Extract 4.47. Stating/Informing speech act

| | | |
|---|---|---|
| **1** | **SO3:** | ***OK: I nak rasa you punya jaws dekat sini:*** *bukak mulut: close:.bukak: close:.tunduk: tak tak ni tunduk: kekiri:* [Ok. I want to feel your jaw here. Open your mouth, close, open, close, bend your head, to the left..] |
| **2** | **P3:** | (Following the instructions by carrying out the 'activity') |

Extract 4.48. Stating/Informing speech act

| | | |
|---|---|---|
| 1 | SO7: | ***Saya nak check sini.[1]*** [I want to check here – this part]<br>**pointing his jaw and the patient follows** |

****SO7 gets ready for the checking session and later comes back to the patient for the jaw exam****

Prior to directing the patient to perform an action(s) *(See the first bullet point under discussion above)*, the students-operators make their patient aware of the next activity/procedure that they will have to undergo by informing or uttering a statement as evident in line 1 in both Extract 4.47 and 4.48 above. Another extract to illustrate this kind of speech act enacted by the student-operator is as shown in Extract 4.49, when she clarifies about the reason for the placement of three fingers inside the patient's mouth:

Extract 4.49. Stating/Informing speech act

| | | |
|---|---|---|
| 1 | SO4: | We want to: see how big you can open your mouth. So want to see whether you can put three fingers or still: |
| 2 | P4: | *nod* |

It can be deduced that the student-operator here does not merely perform actions by non-verbal actions but they do at least, minimally interact with the patient. It is done to check their patient's current well-being at that moment, asking their consent, providing explanation and other concerns through speech acts. Hence, the current findings correspond with Clealand's (2013) study where they find that the healthcare provider practices minimal talk with their patient during the examination phases.

## 4.7. Communicative Activities and Manifestations in Relational Talk

The manifestation of relational talk that highlights social relationship and affective meanings apart from transactional function of language (See Section 2.4) is evident throughout the transition of stages during students-patient engagement. This finding corresponds to Coupland's (2000) finding in which he posits that small talk as relational talk "tends to occur at transition points within an interaction" (p. 56-57). The manifestation of relational talk as part of task talk, aiming to alleviate patient's distress in spite of being fundamental aspect in service encounter (Felix-Brasdefer, 2015) is strikingly a common practice amongst the UM third-year dental students with their patient and is apparent the most during the initial phase of dental meeting before all switch into their main concerns of meeting and during leave-taking.

From what the video data offer, the relational talk is either initiated by the patient or the students. The only difference is the proportion or the amount of turns of relational

practice – where a talkative/humorous patient and who is also competent in the preferred language(s) during engagement engages more in a relational talk (that it is also expandable, realized through more/longer turn-takings) and introduces more small talk with students and vice versa especially when s/he experiences a gap of silence during the engagement. Conversely, if the patient is more reserved, his/her operator still initiates shorter turns of small talk at the initial phase before proceeding with task talk concerning history-taking aspects.

Generally, the relational practice aiming to supplement the business at hand can be seen ranging from joking or teasing episodes, other topics on one's background, small talk (asking whether has patient taken breakfast, transportation that gets patient to the clinic, common home background, etc.) phatic exchanges of greeting and goodbye sequences, enquiries on well-being as explicated in Chapter 2. Koester (2006, p.56) argues that the basis to analyzing the non-transactional talk (as relational talk in this study) is not on its structure but rather, solely on its topics. Thus, this section discusses the three main types of relational talk found embedded in the data during the dental session (regardless of phases) under the following topics:

- Ritualistic expressions: Greeting and thanking/phatic exchanges (Section 4.7.1.)
- Small talk (Section 4.7.2.)
- Humor/Teasing and laughter (Section 4.7.3.)

### 4.7.1. Ritualistic Expressions – Greeting and Thanking/Phatic Exchanges

As mentioned in 4.1, greeting exchanges occur when the students and the patient first come into contact, usually at the preliminary or initial phase and this is (also) done beforehand. Even though it is not found captured by the video, but it is often initiated by the students due to spontaneous, hasty and speedy beginning of the interaction. This is as

evident through observation and is further supported from the interview surveys conducted with the participants.

On the other hand, the speech act of thanking also is discernible at the closing phase of the dental session between the participants. These exchanges are the routines, norm of practice in the clinic. This is in accord with existing studies by Gunter Senft (2012) who termed these exchanges during initial and final segments of service encounter as 'phatic communion'.

Greeting serves as a way to open conversation with the patients whom they barely know while thanking (initiated by either the students or the patient) serves an expression of gratitude despite the route to parting. An instance of greeting exchanges accompanied by hand shaking from both the student-operator and the patient is evident in lines 1-2, Extract 4.50 below:

Extract 4.50. Opening phase

**1** SO5: **Hi uncle** ↑ **shake hand** **Jov*** =**

**2** P5: **Hi. So she told me that you're from Sarawak. =**

**3** SO5: = Yea I'm from Sarawak.=

**4** P5: = So am I,

Meanwhile, the thanking exchanges or called as also the ritual-leave taking is as evident in lines 1-2, Extract 4.51:

Extract 4.51. Closing phase

1 SO7: ***Ok lah. Terima kasih eh:*** **[Ok lah, thanks yeah]**

2 SO7 & SA7: ***Sama-sama*** **[Welcome]** **smile and nod at the same time**

As Koester (2006) posits, the ritualistic expressions also serve as a basis to maintain good relationship amongst the interlocutors involved.

### 4.7.2. Small Talk

From the data, the manifestation of small talk as relational talk also is evident between the participants involved. Despite its most apparent existence during the opening and closing phases (as also elucidated in 4.1) small talk also is embedded within the course of students-patient engagement 'in-between session' - e.g. history-taking. This is in accordance with Koester (2006) who states that relational talk can heavily be seen transparent throughout the whole course of a service transaction. Also as mentioned, it is either initiated by the students or the patient. Two engagements show that the patient as a main initiator to introduce small talk with the students and the various topics discussed are digressed especially before passaging into the history-taking session.

The rests of the engagements depict the student-operator who does the 'habitual small talk' during the opening phase. For the student as an initiator, the 'short', 'usual', 'basic' small talk takes place on enquiring about the patient's health being, language preference, meals or breakfast intake before swiftly steering into history-taking.

Meanwhile for the patient as an initiator, the manifestation of small talk is not only evident during the opening phase but also when they sense a slight pause or long pauses during the middle or towards closing phase of engagement e.g. context: the patient patiently sits on the dental chair while the students prepare the tools needed for the examinations OR while waiting for the doctor's arrival into the cubicle for supervision purposes. Extracts 4.52 to 4.54 show the instances in which the students (regardless of role) who start introducing the small talk with the patient while Extracts 4.55 to 4.57 illustrate the instances where the patient as an initiator to the small talk.

Extract 4.52. Illustrating student-operator as an initiator

1 SO3: ***Oh u speak Malay la*** [Oh you speak Malay?]

2 P3: ***Haa: Malay: biasa Malay lah. I bergaul banyak Malay:*** **[Malay, usually Malay. I befriend with a lot of Malays**

3 SO3: ***Uh huh:***

4 SO3: ***Sebab biasa kalau my Chinese patients I cakap English la:*** **[Because usually I speak English with my Chinese patient]**

5 P3: ***Sebab English I tak berapa pandai:*** **[Because Im not really good in English]** ***ha:***

6 SO3: *Oh takpe takpe: Ok untuk I la: you datang nak tampal gigi kan?* [Okay its okay. This is okay for me. You come here to do the tooth/teeth patching right?]

Extract 52. illustrates the first lines captured by the recordings. The first line however suggests that there must be a similar kind of interaction transpired before the recordings, revolving on the same topic pertaining to the patient's language preference. As evident in the first turn above, the student-operator self-selects and enquires the patient about her patient's comfort in using Malay. The alternating turns on this topic ends in line 6 when the student-operator concludes that it is okay for her to use such a language with her. In the same line, the student-operator directly steers into task-talk when she asks "*you datang nak tampal gigi kan*? [You come here to do the tooth/teeth patching right?]". The following is another instance of a short manifestation of small talk during the opening phase:

Extract 4.53. Opening phase

1 SO4: ***So harini sihat.. Mr. rasa sihat?*** [So today you're feeling well, Mr.. you feel good?]

2 P4: *Sorry...?*

3 SO4: *You sihat?* [Are you feeling well/good?]

4 P4: *Sihat sihat:* [Fine, good - healthy]

5 SO4: ***Dah breakfast dah?*** [Have you taken your breakfast?]

6 P4: *Dah dah* [Yes I have]

7 SO4: *SO4: Because harini.. I akan just aaa…tanya* you history *semua untuk* data..then for another treatment then start with the treatment lah. For today no treatment lah eh..just to collect your data: [Because today, I will just. I will ask your history for data collection. Then for another treatment, then start with the treatment. Oh, for today no treatment, just to collect your data]

As Felix-Brasdefer (2015) puts it, small talk can take on various topics and in relation to the dental context – topics revolve one's health, meals intake, hometown and many others. Line 1 and line 5 in Extract 4.53 above also illustrate the manifestation of small talk comprising two topics or concerns when the student-operator takes the first turn and enquires her patient first about his health being and whether he has taken his breakfast before she enacts task talk in line 7 – clarifying the activities they would undergo for the session and moving on to the history-taking session.

Extract 4.54. Illustrating student-assistant as an initiator; Opening phase while waiting for the student-operator's arrival

1 SA5: Uh... Wait for the dentist come eh? = (min. 1.03)

2 P5: = Okay.

*While waiting for the session, patient sits on the chair patiently and looks around the clinic.*

*D.A5 on the other hand displays orientation to the instrumental tasks – preparing all tools and related items for the session*

(after 1 minute 28 seconds)

3 SA5: So you came here by: car is it? =

4 P5: = Yes, I drove my car **while nodding**

5 SA5: So you park at the parking there = *pointing finger*

6 P5: = Yeah, parking there *pointing finger* But too packed eh..

7 SA5: [yahh

8 P5: [Too many people

9 P5: *Ini dekat luar sana* office, you know *dekat.. itu: signal uh: hampir: hampir hampir: 10 minit saya dapat.. baru saya dapat masuk*. [This outside office there, you know, close to, uh,the signal nearly nearly nearly 10 minutes I get... only I can get in]

10 SA5: *nod* uh-huh

11 P5: So you are: student in the faculty here is it? = ↑

12 SA5: *nod* = yah: student

13 P5: [and where is]

14 SA5: [Jov***'s assistant.] =

15 P5: = you are his assistant uh: how many years? = *with hand gestures*

16 SA5: = Uhh now I'm in third year..

17 P5: [Second. Third year uh:

18 SA5: So I have two more years, =

19 P5: = Okay so five years all uh: = *nod*

20 SA5: =Yeah five years.. =

21 P5: = Okay very good ↑↓So are you happy? =

22 SA5: *snicker and nod* = yeah.

23 P5: = Happy ah, okay,

24 SA5: *nod*

25 P5: ( . ) So: where do you plan to go: after this? Posting: where are you ( . ) *tempat yang you suka*? [place that you like?]

26 SA5: **chortles** he he he. hmmm: I: don't know yet: =

27 P5: = Maybe Sarawak? =

28 SA5: = Sarawak? =

29 P5: = *Suka pergi Sarawak?* [like going to Sarawak?]

30 SA5: Ha ha ha oh no no no, **hand gestures showing 'no'** that's too far, :

31 P5: *pergi dah?* [been there?]

32 P5: *Pernah pergi Sarawak? Maybe jauh, tapi dekat ( . ) sejam boleh sampai.* [Have come to Sarawak? Maybe far, but near. can reach within an hour]

33 SA5: I'm from Ipoh.. =

34 P5: = You're from Ipoh? *[Jauh lagi:] Ipoh pergi: Sarawak. Jauh lagi* one and a half year. Eh one and a half hour. = [you're from Ipoh? that's farther away, Go Ipoh, Sarawak. that's farther away and a half year. eh one and a half hour]

35 SA5: [Half hour..]

36 P5: = *Ipoh: dekat dua: dua jam [setengah]* [Ipoh almost two, two and a half hour]

37 SA5: *[dua jam* [two hours]*:]* =

In the absence of the student-operator, the student-assistant initiates interaction with the patient by first asking him about the transport that gets her patient to the clinic. Afterwards, the topics are seen vary from time to time – the patient initiates all the pro-social topics for the most part; about the 'parking lot around the faculty', 'patient's and assistant's hometown', 'student's preferred place for future posting', 'students' practical work' (lines 6-32). Most of their utterances of small talk that latch without any pause also depict their interests in getting to know each other and build camaraderie.

Additionally, this former claim made is also parallel to the idea by Sami Ali (2016) who postulates that latching, other than overlapping signals the closeness between interlocutors.

Extract 4.55. Illustrating patient as an initiator

| | | |
|---|---|---|
| 1 | P1 | So: How long ( . ) will all of you graduate? **while doing hand gestures** |
| 2 | SO1 | Two more years. |
| 3 | P1 | Wahh ↑ **claps** |
| 4 | P1 | Dr. Afifah : She'd been tied down for 10 years. So now she's third year already ah. She got [7 more years]. |
| 5 | SO1: | [Ah I see : ] = |
| 6 | P1 | = You know her? Your colleague. Afifah. She's the one who... |

****SO1 and SA1 speak with each other about the 'mentioned' person. Though, their interaction here is not really clear****

| | | |
|---|---|---|
| 7 | P1: | ( . ) You all local? From KL? |
| 8 | SO1: | Uh : No. I'm from Kuantan. |
| 9 | P1: | Huh very good. You come here, you escape the bow side. You? **pointing the D.A1** |
| 10 | SA1: | **chuckles** = I'm from Terengganu. |
| 11 | P1: | Terengganu? Wow la:gi best. cantik woo. The beach there, pantai. Sini west coast ( . ) **shake his head* kotor la. Sana : pantai: putih ah?* [Terengganu? Wow more exciting. Pretty woo. The beach there, beach... here west coast is dirty. There white beach ah?] |
| 12 | SA1: | Mhmm **nodding** |
| 13 | P1: | S*ana..pantai* sand ahh? Quite sand ah? **both students nod* Sini..* Here all are conta:minated by all :the vessels, all the way from the streets of Malacca. *Kotor sangat..* [There..beach sand ahh? Quite sand ah? Here. All are contaminated by all the vessels, all the way from the streets of Malacca. Very dirty.] |

The above extract depicts an instance where the patient who initiates an effort by opening ways to informality by introducing a different topics of small talk with the students (lines 1,6,7,13). The students do not digress the topics raised by the patient nor ignore the small talk introduced by the patient. Rather, they project minimal responses in the alternating turns (one instance shows overlapping turn (line 5) such as *"aha, I see, hmm"* as evident in lines 2,8,10,12 accompanied by a warm smile and chuckle that is expressed through their soft voice of tone. The following extract on the other hand, illustrates the hybridity of small talk during history-taking that takes place among other participants:

Extract 4.56. History-taking phase: hybridity of relational talk within task talk

| | | |
|---|---|---|
| 1 | SO5: | Never wear the denture before? |
| 2 | P5: | No: never |
| 3 | P5: | (XXXX) |
| 4 | SO5: | I'm going to be like: |
| | | ( . ) |
| 5 | P5: | You're a Bidayuh or Chinese? |
| 6 | SO5: | Er..Chinese |
| 7 | P5: | You look like a Chancorek. (xxxx). Normally they're like Bidayuh right. |
| | | *Both students laugh* |
| 8 | SO5: | Yeah |
| 9 | P5: | I know a lot of Chinese. In the town there yeah. |
| 10 | SO5: | Yeah yeah |
| 11 | P5: | You know hakka hokkien? |
| 12 | SO5: | Hakka |
| | | ( . ) |
| 13 | SO5: | When is the last dental session before. For uh: excision |

The patient initiates a small talk with the student-operator by enquiring him about his ethnicity background (line 5). This is initiated by the patient who breaks the short silence as the student-operator is in the midst of inhabiting the information revealed from the computer. Such an instance where a small talk is implemented with aim to break the silence gap is also a common phenomenon between interlocutors (Jaworski & Coupland, 2014). The small talk ends when the student-operator enacts task talk by enquiring the patient about his last dental session in line 13. Again, the same patient fills the gap by initiating another small talk as evident in line 5-13, Extract 4.57 below after sensing a pause within the same phase:

Extract 4.57. History-taking phase: hybridity of relational talk within task talk

1 SO5: Is it ↑↓something called: 'salbutamol'?

2 P5: yes. yes. yes: **pt. nods**

3 SO5: salbutamol..?

4 P5: yeah correct correct.****silence/pause****

( . )

**(mins 11.39 – 12.03 : 1 min 3 secs)**

5 P5: So how often you go back to uh:

6 SO5: Maybe like uh: once ↑ in a sem.

7 P5: *(pt nods)* okay, okay:…….

8 SO5: Last time I went back uh: one month ago. =

9 P5: =Okay.= *(pt nods)*……

10 SO5: = As long as there is a long sem: then I'll go back.

11 P5: (pt nods) Ah I see, okay……

12 SO5: But one week: ↓ maybe I'll just stay here.

13 P5: Uh huh: okay okay.

(*quick pause/short silence)

( . )

(4 seconds)

14 SO5: Have you done any: scaling?

15 P5: No no no……

### 4.7.3. Humor/Teasing Aspect in Small Talk

Teasing is one component associated with humor (Ojha & Holmes, 2010). One from ten engagements reveals the significant occurrence of humor/teasing aspect accompanied by laugh voice, exaggerated tone and winking enacted in a small talk initiated by a patient to the attending students. This is evident throughout the dental engagement; from the opening to closing phase. As the patient puts it, s/he purposely teases them in order to make him/her feel better as s/he feels scared and distressed sitting on the dental chair. These mental models are aligned with the ideas proposed by Miller (1996), Morreall (1991) & Keltner, Capps, Kring et al. (2001) who posit that such teasing, as a 'playful provocation' helps alleviating stress and (also) bonding relationship between interlocutors. The following extract is one example taken during their initial phase of engagement when he queries about the researcher's attendance around the polyclinic. The teasing aspects are as evident in the bolded sentences below, taking place during the opening phase:

Extract 4.58. Opening phase

1 P1: **Turn his head gazing the SO1**

2 P1: *Ni Syira, dia selalu ada ini macam ke interview ahh?* ↑= [This
Syira, is she always having this practice..interview ahh]

3 SO1: = *Takk* = first time = this is first time [No, this is the first time]

4 P1: Woo. I very lucky ↑ **putting his hand on his left chest** So I'm lucky. ↑

5 SO1: Yeah .hhh Lucky] ↑ ( . ) lucky ↑**grins**

6 SA1: [Heh heh heh first ↑

7 P1: ***Ada (.) dia nak bayar saya?*** [Any chance that she pays me?]

8 SO1: ↓ ***Tak tahu la:*** [I don't know..]

**( . )**

9 P1: ***Belanja makan ke: Nasi ayam pun takda, ?*** [Treat me food..Chicken rice also don't have?]

****winking****

10 SO1: ***Tak tahu la,,. *grins*** **You ask her lahh.** [I don't know. You ask her lahh.]

****Both students are getting ready for the history-taking session by the behaviors shown in***

***video. They are seen to prepare all equipment needed for the session****

11 P1: **Just kidding laaahh ….** ↑↓ **(**grins and hand gesture indicating 'no'*) Kita support: kita support:** ↑↓ ***( . ) Apa apa acara kita kena support kan: (*while D.A1 ties an apron on this patient that covers his shoulder*) Untuk pertolongan semua semua.*** [Just kidding lah, We support, we support. Any events we have to support right? To help]

**Dental students seem to double check everything and instantaneously start the session**

12 SO1: Mhmm. *(and jump straight to the first question)*

(0.7)

13 SO1: So uncle: do you have any complaint or any pain? =

(mins 2.48)

The teasing aspect is discernible in line 7 initiated by the patient and ends in line 11 when the patient clarifies about how he intentionally victimized the students by his teasing behavior when he vocalizes "just kidding lah". The student-operator utilizes a non-lexical backchannel response *"Mhmm"* in line 13 as a strategy to 'cut' the talk and proceed with the session. As the interaction progresses, there is a noticeable shift after a slight pause in line 11 from the teasing aspect of small talk to the talk related to the business of the visit; task talk when the student-operator poses the first question to her patient for 'history-taking' information purposes (lines 12-13).

In short, the emergence of these relational talks regardless of phases supports the practice and the flow of FoDUM clinical engagement which in simultaneity affect the general satisfaction level of the participants involved. This claim is further analyzed and elaborated in Chapter 5.

# CHAPTER 5: DISCUSSION

## 5.1. Introduction

This chapter aims to address RQ3 that seeks to document or present on the student-operators' and the patients' experiences, opinions and views in relation to their satisfaction level and communicative challenges when engaging together. An inspection on the survey data brings this chapter to comprise three main sections. The first two sections reveal about the student-operators' satisfaction that are further divided into two. The first part is on 'high satisfaction' and the second part is on 'low satisfaction' that is supplemented with relevant communicative challenges influencing such an outcome. This is equivalently done for the patients in the final section. The chapter outline is as below:

- The Student-Operators with Favorable Experience – High Satisfaction (Section 5.2)
- The Student-Operators' with Unfavorable Experience – Slightly Low Satisfaction (Section 5.3)
- The Patients' with Favorable Experience – High Satisfaction (Section 5.4)

The discussion is supplemented with the evidences gained from the interview data. The data triangulation is done, but only one out of ten engagements reveals the instance of communicative challenge faced by the student-operator from the captured video and audio data. This might be due to video/audio failures or the students' forgetfulness on switching on the instruments back as raised by the student-operators during the interview session.

From the survey data, six student-operators express their satisfaction with the engagement whilst another four student-operators claim about their unfavorable

experience which lead to slight dissatisfaction due to different or similar communicative challenges/reasons. Nevertheless, all ten patients express their utmost satisfaction with the engagement.

## 5.2. The Student-Operators with Favorable Experience – High Satisfaction

High satisfaction' is used as a theme in this section referring to the high rating rated by the operators and the smoothness of an engagement experienced by the attending student-operators.

### 5.2.1. Bonding Through Relational Talk Creates Satisfaction

One of the factors that influences the student-operator's satisfaction is his ability to build rapport with the patient by practicing a relational talk. Precisely, the patient's nice/pleasant personality as discovered from the way they practice small talk about their hometown creates satisfaction to the student-operator. This is shown in the following excerpt:

> *"It was very smooth. **I like talking to him**. First... He's from my same hometown, he asks me that I'm from Sarawak, and I said which part of Sarawak then he said from Kuching, I said I'm from Kuching too and then we talk a lot about…Kuching. asked him a lot of things and then... he is nice, he's very very nice" – SO5*

### 5.2.2. Using a Language Preferred by the Patient

Another student-operator who is satisfied with the engagement describes 'satisfaction' when she is able to speak the language preferred by her patient. To her, such practice helps her creating the bond with the patient. Additionally, it allows the process of scrutinizing information from the patient to be much easier. To her, there is a strong

connection between acquiring information and the mutual and ideal use of their preferred spoken language/languages:

> *"Yea smooth... Usually if I'm talking to a Chinese patient I'll tend to use language that they prefer Chinese or a mix of English and Chinese...uh if its Malay and then I'll tend to use Malay because it helps to create that bond between... you know. The operator and the patient. So they'll feel like they'll more to share information with you" – SO8*

### 5.2.3. Achieving Patient's Understanding through Mixed Languages

The third component that influences another male student-operator's satisfaction during patient engagement is through his ability to speak mixed languages with the patient. This interactional style is enacted after discovering that the patient speaks in such manner (hence, accommodating to the patient's way of interacting). According to him, this practice in general aids the practitioners into gaining an understanding from the patients about what is communicated to him/her. The following excerpt illustrates the aforementioned statement:

> *"Uh yeah. Smooth. I used English and Malay with the patient.* ***Because sometimes I find the need that patient more understand when people use "rojak rojak"*** **[code-mixing] ...** *She also sometimes used English and sometimes Malay. To be honest I'm not really good at all these medical terms so I use all those... normal terms to the patient" – SO9*

The remaining three student-operators who are satisfied with the engagement frame their views as in the following:

*"It's smooth and I'm satisfied, because* ***patient umm is very compliant, she listens to your every word except that you need to speak in BM lah, because she can't listen and can't speak in English. So if I manage to understand her BM and if she can understand my BM then that'll be fine****. So this what happens on that day"- SO2*

*"Masa dengan dia eh? Sebab.. kebanyakan patient saya lebih kurang umur macam tu jugak (elderly), so tengok semua..* ***diorang okay la sebenarnya****. Diorang suka bercerita….****takda masalah lah****" [When I was with her? Because the age range of my patients are like that (elderly), so with/seeing them all...****they are actually okay****. They like to chat.* ***So there's no problem.] –*** *SO7*

*"I think the communication between me and my dad uhh is smooth. Sebab rasanya.. because dah biasa kan.so takde apa apa..****apa apa masalah lah****" [I think the communication between me and my dad uhh, is smooth. Because I've been used to this right... so there was…* ***There was no problem****. (note: the patient also is her father and this finding might be bias and void] – SO10*

Nonetheless, the former claim made by SO2 however catches the researcher's attention despite her satisfaction (an engagement involving a Chinese female operator, a Chinese male assistant and their Indian female patient) because the previous analysis shows that the Indian female can barely speak Malay through the explanation given in response to a 'No'- question-type posed during history-taking. As mentioned in Chapter 4.3, the preferred language between these interlocutors is Malay since the patient knows a little English or close to not knowing English at all. She speaks her second language

which is Bazaar Malay with people who do not share the first language as hers but her styles of interacting can lead to confusion amongst the people/hearers – as experienced by the researcher herself.

Additionally, she also minimally interacts with her operator (only when questions are posed – see Extract 4.10). They are found to shake head in disagreement or 'nod' in signaling their mode of understanding despite the fact that whether they understand each other is questionable. This is pointed out from an analyst point of view, a person who also interacts with the same patient (in Malay) during the interview session. Above all, both active agents here claim that they are both entirely satisfied with the meeting.

The last two claims made in relation to satisfaction are expressed to show the student-operators' sense of smoothness about the engagement. Plus, they further mention that they (ultimately) have no issue at all with the engagement. This eventually provides them a great satisfaction.

## 5.3. The Student-Operators' with Unfavorable Experience – Slightly Low Satisfaction

Meanwhile, four student-operators are slightly dissatisfied with their engagement involving the patient. This section discusses the qualifying statements made when they claim about their unfavorable experience which simultaneously reveals the issues or communicative challenges that influence their entire satisfaction with the engagement.

### 5.3.1. Talkative Patient Delays Treatment

One student-operator appears to feel much disappointed with her patient when she hopes to accomplish all the compulsory procedures of the entire session on the same day. This hope, unfortunately is not attained due to the difficulty in managing her talkative patient

within a limited time frame. As she repeatedly proclaims - *"he generally takes time a lot and talks a lot, he tells stories, everything about his father, mother, etc."* more than what is necessitated for the purpose of making a diagnosis. In addition, she reports that she does not want to 'ruin' the relationship with her patient either.

Her patient occupies more floors and turns in responses to the questions raised. The outcome of such practice invites backlog for both parties as they have to set another appointment in pursuit to completing the patient's dental concerns.

From data triangulation, this scenario can be found from the video data and the aforementioned challenge is repeatedly acknowledged by the student-operator from the interview. A small instance from the video data is as shown in the following extract:

Extract 5.1. During history-taking when the student-operator asks about the patient's family and their serious illnesses

1 SO1: *So sekarang dia?* [So how is she now?]

2 P1: *Sudah meninggal.* *[Has passed away]*

3 SO1: *Sebab?* [Because?]

4 P1: *Dia meninggal sebab jantung enlarge=* [She passed away because the heart enlarged]

***Student-operator nods***

*5* P1: ***=Abang ketiga, dia 3 years ago dia ada kerja dia ss2. Lepas lunch time: Dia lepas makan nasi kandar dia jalan kaki: balik office. Tiba tiba I think. Dia ada cardiac arrest. Dia ada buat dari country jaya ijn. Bypass. About 18 20 years ago. He got by pass. Country jaya punya: Itu buat mahal sikit. Same thing la. Then came out everything ok. Then mesti ambik ubat la. Then lepas lunch balik kaki office. Dia ada cardiac arrest. I think fall down ka: I think dia terduduk la takda fall down. SS2 sana kan. Telefon ambulans. Masa itu manyak jam. Ambulans pun lambat. So lepas tu. Sampai sekarang kita nak cari dia tak dapat cari dia. Ajak dia mari. On the way.*** [My third brother, he worked at ss2 three years ago. After lunch time, he went back to office just by walking. Suddenly I

think he got cardiac arrest. He had done bypass at 'Country Jaya'. 'Ijn' about 18 20 years ago. At Country Jaya, it was quite pricey. But when he came out everything was okay, he just needed to take medicine. Then after lunch when he walked to the office, he had cardiac arrest. He broke down and sat onto the ground. The called the ambulance, that time it was heavily congested. Ambulance also came late. So after that. Until now we have been wanting to find him but could not. Asked him to come. On the way]

***Student-operator nods***

6 SO1: Ohhh:

7 P1: *So dia masuk: Dia masuk sendiri masuk emergency masuk* immediately *itu orang suruh balik. Itu orang suruh balik. Dia tak kasi tinggal nama. Nurse ah.* [So he came in. He came in alone to the emergency room then that person asked him to go. She doesn't even allow to leave name. The nurse]

8 P1: *Dia telefon anak semua: Nurse. Baru kita tau la. Semua datang dia sudah habis*. [She (nurse) called everyone – the family to let us know. When we came he had gone]

9 SO1: Uh huh

10 P1: So my family *ada heart problem* *[So my family has got heart problem]*

11 SO1: *So uncle memang semua ada heart problem la: complication:* [So you and your family have got heart problem, complication]

***Patient nods***

( . )

12 SO1: *Uncle tak ambik alcohol kan?* Uncle just smoke. [Uncle does not consume alcohol right?]

13 P1: *23 24 tahun* [23 24 years]

As illustrated in the above extracts, the patient enriches the context of experience and knowledge by providing a narrative about his 'family-stories' when he extensively describes about each of his family member and the related disease encountered as highlighted in the excerpt (Line 5, Extract 5.1). Based on the evidence from literature, this act helps a lot in supplementing an additional info to a good diagnosis (Ong et al., 1995; Bayoumi, 2004). In addition, the patient thinks that supplying his "family-stories" information to the history-taking process can justify his qualifying remarks. However, the student-operator finds the opposite and it is a major challenge to her when she further

claims that she fails at interrupting and 'steering' to the patient's talk after **discovering the adequate information needed**. Also, she intends to avoid offending him by interjecting his talk. In response to dealing with such a patient, the student-operator further presents her views as in the following:

> *"I rasa a bit frustrated. My target nak habiskan examination, diagnosis and everything on that day but I cannot proceed to the next step"…* *[I felt a bit frustrated. My target was to complete examination, diagnosis and everything on that day but I cannot proceed to the next step]* *"Tak habis tak sempat present pun...tapi...sebab...dia.....dia…..ambik masa…dia cakap banyak sangat……..…..even though,kita cari..jalan nak interrupt tapi dia still keep on cerita cerita cerita"* *[Not able to even make a presentation... but... because... he took time. He spoke a lot. Even though we searched for ways to interrupt but he kept on droning with his stories.]* *– SO1*

From the excerpt, the student-operator expresses her great disappointment for not being able to progress further due to engaging with an overly talkative patient. Two other student-operators also point out about the same issue regarding talkative patient as shown below:

> *"Sebab kita tak ada banyak masa... limited time. So macam kalau talkative patient tu dah memang jauh cakap tu kita terpaksa interrupt la"* *[Because we don't have much time...our time is limited. If the talkative patient goes beyond/ overboard then we have no choice but to interrupt.]* *– SO3*

*"Patient yang banyak cakap la...**susah nak cut**. Kadang kadang tu kita pun macam kejar masa kan.. Kita pun nak buat itu buat ini. So kalau patient yang banyak cakap ni rasa macam uhh.. susah jugak la kadang kadang. Sometimes... my partner la, will help me la"* *[The patient who is talkative. It's hard to cut them. Sometimes we are rushing. We have to do this and that. It's quite difficult dealing with talkative patients. Sometimes my partner will help me.]* *"Dia melambatkan lah"* *[he/she (patient) delays the processes]* *– SO10*

As the above boldface utterances show, the other two student-operators also posit their struggle in managing a talkative patient and how such a patient delays the dental progression within the confined time they have. In addressing this situation, Chatten et al. (2013) propose that students should be honest and as clear as possible about the allocation of time for the whole duration of an engagement. This is to ensure that everyone can escape from being carried away with their topic(s) of conversation.

### 5.3.2. Communicating Technical Terms

The interview data also reveal the student-operators' distress on the use of technical terms when immersing in a real dental practice with various patients. According to Chatten et al. (2013), this is a common case when clinical notes are full of technical terms that students are known of. Only one out of ten student-operators is found to not be affected with the technical terms when he claims:

*"To be honest uh, I'm not really good in some of the technical terms la, so I use all those normal terms and sometimes when I present to the doctor, the doctor says why don't I even know the medical terms" – SO9*

Despite this instance, the remaining student-operators express their concern on this issue. This is shown in the following excerpts:

> *"But sometimes kitorang ada masalah, sebab kitaorang belajar Bahasa Inggeris, lepas tu ada term term.* ***So bila nak explain kat patient ada term yang kita macam.. susah macam nak cari word apa yang Malay or English yang senang bagi patient faham"*** *[But sometimes we have problem, because we learn everything in English and all the terminologies. So when doing the explanation, it is difficult for us to find Malay or English words that can best suit the terms and which are understandable to patients.] – SO4*

> *Cuma..bila yang term term dental kitorang kan belajar dalam bahasa Inggeris, English kan.* ***So nak tukar dental English to Malay tu..macam nak terang ke layman term tu susah jugak"*** *[It's just that…we learn all the dental terms in English. So it's quite hard to translate English dental terms to Malay] – SO6*

As indicated in the above excerpts, the student-operators have been struggling in translating the technical terms in an appropriate manner in order to meet their patient's understanding by using the language preferred by the patient. Taking Laszlo's (2013) stance, he suggests that **constant** checking with the patient *vis-a-vis* the explanation made about a technical term is a crucial practice for the students as the primary function of effective communication in dental care setting is to reach a mutual understanding between participants involved (Nield-Gehrig, n.d).

### 5.3.3. Intercultural Communication

Intercultural communication is a situated communication amongst interlocutors or groups who do not share similar linguistic properties and cultural origins (Lanqua, n.d.). The following excerpt signifies the previous basic definition when another issue is encountered between a student-operator and her attending patient who differs in their ethnicity. They interact in Malay with each other, as requested by the patient.

> *"Tapi macam patient tu dia boleh cakap Malay, tapi macam...* ***sebab dia Chinese kan....bahasa utama dia still Mandarin jugak la,*** *so macam dia ada problem macam..gum problem tau. pastu kalau I nak explain kat dia macam apa yang buatkan gum problem tu, so I macam cakap la, oh ur gigi ada calculus so calculus tu macam tahi gigi yang keras kan, tapi dia macam...* ***dia macam susah nak faham jugak*** *la.* ***So macam, my partner is Chinese right, so dia tolong translate la"*** *[But the patient she could speak Malay but like…****since she's Chinese, her main language is still Mandarin.*** *So she was having this gum problem, then I explained to her what causes to the gum problem and I said, oh your tooth/teeth has/have got calculus. Calculus is like hard fecal bacteria right, and she was like...* ***she seemed not to understand / signaling difficulty in grasping my explanation***. ***So like, my partner is Chinese right, so she helped me doing the translation.] – SO3***

As this instance reveals, the student-operator claims that her Chinese patient displays a great difficulty in comprehending the explanation made by her, regardless of the earlier agreement and preference made by the patient that Malay language should be the main mode of interaction throughout the session. To overcome this, the student-assistant who is also a Chinese assists the student-operator by translating the earlier explanation made

into Mandarin to ensure that the patient fully understands about what is communicated to her.

Even though the student-assistant does not share or cannot speak the patient's first language, the student-operator who faces such a difficulty would still seek help from other relevant colleagues to do the translation as revealed from the interviews. According to them, translating the language used by student-operators is necessary as it can ensure their understanding on the messages conveyed, thus are able to satisfy patients' needs in general.

Based on these results, it can be implied that these third-year novice student-operators who are yet to become experts at this stage prefer a patient who knows the language(s) as they do, who is not overly talkative within the time allocation and who can adequately listen and align with more or less similar amount of speeches projected by them, regardless of the patients' social backgrounds.

This is crucial in ensuring a linear and smooth progress of the session and though if it is not completed, the blame does not result from the patient's personality but from their own incapability to sort the dental concerns appropriately as prescribed by the doctors/supervisors. From the data, the incomplete session is directed to the patient's talkativeness as opposed to the technical inconsistencies (that might be) perpetrated by the students themselves.

### 5.3.4. Differences in Patient's Personalities vis-à-vis Introversion and Extroversion

The survey data reveals the situation where a student-operator mentions about her patient's personality as a friendly and talkative patient, hence extrovert, and how this trait affects the dental progression and her satisfaction (see Section 5.3.1). However, as shown

in Chapter 4, the remaining student-operators here who are also mainly dealing with an introvert patient (who only speaks when the student-operator speaks to him/her) may encounter hidden 'diagnosis quality' problems despite their expression of satisfaction. This is distinguished through the way they 'minimally and maximally' respond to/interact with the attending operator from the present engagement shown in the video.. Thus, this section provides a remarkable point of discussion as each personality whether explicitly or implicitly realized by the students (and despite influencing into slow or fast progression) may influence the entire quality of the diagnosis-making. Hence, the students' outcome of an engagement despite their claim of being satisfied or dissatisfied is elaborated.

The analysis with an introvert patient shows that his/her attending student-operator is able to manage their turn-taking system wisely as such patient talks and responds only when questions are thrown (hence, less interruption and digressed topics). However, the issues may arise whether does the patient provide sufficient and adequate information (even when being probed) for the diagnosis making and does s/he truthfully understand the important information being channeled through the agreed language used as a mode of interaction? (see Section 4.4 and 4.5).

As discovered from the relevant data, these introvert patients are strongly associated with those who do not share the first similar language as the student-operator, with relatively moderate educational background, and those who have limited knowledge in the second language (e.g. English) . Additionally, their concerns may particularly be directed to getting their tooth or teeth fixed than displaying extroversion with the healthcare provider.

Meanwhile, the communicative acts such as providing a narrative and enacting too much relational talk by an extrovert patient along the engagement would help a lot in

the diagnosis-making. This is because these acts help give student-operators a better understanding about a patient's life problems/stories and help establish a good rapport. However, in another extent, this study shows that such acts by the patient create a slight displeasure among the novice student-operator. In particular, the novice student-operator may experience time pressure especially when he himself does not know how to end a topic interrupt or manage turn-taking. He may be anxious too about the later presentation as it is regarded as a partial requirement before proceeding to Part 2. The next section shows the particularities directed to the patients.

### 5.4. The Patients' with Favorable Experience – High Satisfaction

Besides that, an initial examination against the survey data from the patients also is done to reveal the significant themes about the patients' opinions/experiences that influence their satisfaction and communicative challenges (but eventually there are some subjects that do not affect their satisfaction) when engaging with the students.

#### 5.4.1. Patients' Reasoning to High Satisfaction

Notwithstanding the student-operator's opinions and communicative challenges, it is evident from the data that all ten **patients generally** express their **satisfaction** with the service and care provided by the attending dental students. This is evident when all of them mention the following word/phrase "satisfied/all satisfied". The supplemented responses and reasoning to why they are satisfied are shown in the highlighted excerpts below:

> *"Yes they were very careful in their examination…They are very good, they are very care-giving to their patient, no private deals among the two students…**very***

***professional. Communication no complaint. Presentation no complaint****..." "I'm all satisfied", "they were very professional" - P1*

*"**Satisfied**…yes, I think I think they give me a thorough checked, inform me the findings" – P.4*

*"Perfectly **satisfied** because I find the doctor who was attending – the students, they were very polite, very caring... **every time whatever he wants to do he will tell me in advance. so I was mentally and emotionally prepared….it was two-way of conversation**" – P5*

*"Overall, **puas hati.** Soalan yang dia tanya very straightforward dan apa yang kita tanya pun dia boleh jawab" [**Satisfied**. The questions he asked are straightforward and he can answer the questions raised to him] – P6*

*"**Puas hati** sebab apa yang dia buat tu sempurna..bila saya tanya..**dia jawab detail lah.** Lagi satu dia check saya..gigi gigi saya semua. Dia kata tak ada masalah, ada yang rosak ada yang tak rosak, ada yang boleh cabut ada yang tak boleh cabut…..tapi saya **puas hati lah**." – P7 [**Satisfied** because what he'd done was all perfect... when I asked, he gave **a detailed reply**. One more, he thoroughly checked my teeth. He mentioned that there's no problem with my teeth, but mentioned about there was broken and unbroken tooth, some can be extracted and some cannot... but I am all satisfied]*

*"**Puas hati** sebab dia detailed and cara explanation pun detailed lah" [**Satisfied** because **he went so detailed** and **gave detailed explanations]** – P9*

*"Memang puas hati lah dengan session tadi. Tak ada apa apa isu yang serious pun."*

*[Was really satisfied with the previous session. No serious issues arose] – P10*

Despite being anxious about dealing with different types of patients, the attending students still exceptionally attend those patients politely and professionally. This is primarily in pursuit to gain the patient's satisfaction. All patients give high ratings of satisfaction for the attending students. Moreover, the comments and explanations given by each student-operator are distinctive for the following practical reasons – the students are caring, polite, meticulous/careful in the examination, no private deals among the operator and the assistant, two-way of conversation, questions are straightforward, and detailed explanations.

### 5.4.2. Technical Terms

Despite the high ratings given for the attending students, there are three patients who additionally concern about their slight difficulty in grasping the technical terms (whether accidentally or non-accidentally) vocalized by the students. However, they claim that this kind of difficulty does not influence their satisfaction and perception about the operators and the engagement as a whole. Additionally, the same issue is the only similar communicative challenge confronted by more than one patient. The evidences are shown in the following excerpts:

*"There were some terms…like **caries** and I say what is that, I didn't know what she tried to tell me…whether I can digest or not I don't know. I have to go back and look at my dictionary again *laugh*" – P1*

*"Even though I don't understand the terminology…there's a **filling** here, and **crown** I'm not to sure what is **crown**" – P4*

*"Banyak jugak **code** yang saya tak faham. Apabila..doktor datang bagi pemantauan dekat apa.. dekat computer baru menyerlah mana gigi-gigi kita yang tampal...ada masalah [There were quite a few codes that I did not understand. When the doctor came for supervision...with the aid of computer, only then it became obvious about our plastered teeth, the likely problems...] – P10*

The first quote attracts the researcher's attention when this patient as observed from the video data clarifies to the students about his familiarity with some of the technical terms, as gained from his previous schools. Additionally, he also speaks some of the technical terms which made the students feel stunned and awed at the same time. (see Extract 28). Due to that reason, the students may have mistakenly taken the claim as a token to use other technical terms in the following phases when this, in reality still confuse the patient and his understanding. To some extent, the patient somehow contradicts himself and his claims when engaging with the students and when the researcher is present there during the interview session.

### 5.4.3. On-The-Spot Advice to Build Patient's Trust and Confidence

One out of ten patients suggests that the student-operators need to improve their skills more in dealing with the patients who demand on-the-spot explanations when being enquired on the treatment recommendations and precautions needed for oral health improvement. This is to ensure patient's trust is gained and a good rapport can be built

between the doctor and patient in general. For example, in this response, *"there's no cure, just take care of your teeth - (P1)"* this patient claims that he does not expect a total cure in the late 60's. So, he presents his comment this way:

> *"I need on spot explanations; students maybe could improve on this area. Maybe this patient needs supplement, maybe he needs to work more on that area, maybe I should gargle after my meals, etc." – P1*

Nevertheless, as he repeatedly proclaims, such matter discussed is not a serious issue encountered when he says *"no issue, no problem, no complaint"*. It shows that he is not disappointed and this situation does not affect his entire satisfaction with the engagement. The other main reason to this outlook is also as presented by other patients as discussed in the following subsection.

In this regard, Chatten et al. (2012) mention that the students should practice to reiterate and acknowledge the patient that they are still learning if asked about particular diagnosis they are not able to deal with. They need to provide notification that such queries and requests for information will be addressed by respective doctors/dentists.

### 5.4.4. Students – Learning Stage

Above all, **the patients do not view any minor inconsistencies arose with the students** (e.g. the use of technical terms, lacking in giving 'convincing on-spot explanations') **as major problems that can directly affect their entire level of satisfaction**. This also implies to the reason why the students receive positive feedback and high rating. The patients are satisfied and pleased with the care given by the attending students. Another point is also directed to the patients' understanding about these students' state of being in

which they are still in their infancy phase and still at the learning stage, thus, inexperienced. This claim is evident in the following excerpts:

> *"Of course she does made mistakes but acceptable mistakes (description was wrong; identification was wrong[1]) but I'm not complaining because she is still* ***a student. I'm not upset with them****" – P1*

> *"Ada certain...mula-mula check sekali tak nampak benda tu, then check dua tiga kali, dua kali lah check baru nampak lah, apa yang problem dekat gigi tu....tak lah kecewa sebab* ***dia orang pun belajar kan****.." [There was certain…. Initially when checked can't see that 'thing', after checking for two or three times, or two times of checking only can see the problem at the tooth/teeth. Not disappointed because they are* ***still learning]*** *- P6*

Another two patients also frame a similar thought as above but in brevity (as shown in the next excerpts) especially when they are further probed about the high rating or why they mention about their lacking but still repeatedly mention that it is not a judgment or any serious issue nevertheless:

> *"Mungkin dia masih dalam belajar lagi" [Maybe because they are still learning] – P10*
>
> *"Sebab saya tahu dia practical" [Because I know he's doing 'practical' / dentist in training] – P7*

[1] As claimed by the patient, this is discovered when the doctor points out the students' mistakes in his attendance.

It is rather difficult to distinguish the other communicative themes that can best depict the patients' dissatisfaction **since all responses given are entirely marked positive**. Even though they can pick the students' 'flaws', they will eventually come up with the idea that it is not a real plight and that they are still satisfied with the care given, taking the stance that the students are inexpert dentists-in-training.

The only major concern as raised by one of the patients' is relating to the students' doctor/supervisor as part of the participants involved in between the session. This patient mentions that the attending doctor should be friendlier so that he appears more professional. This suggests that the doctor's (as the third party) act also influences the patient's whole satisfaction level with the engagement – since s/he is part of the dental practice.

> *"The doctor was not so professional. He didn't ask anything about me. Like is there anything I can do for you. He just had communication with the students. At least some communication between the doctor and the patient. Being a doctor, show your professional. I'm not saying that you must treat me as a King or Queen. I'm not asking for that. You're talking about communication and you want to get as much information from us. I think you should work on the doctor's rather than the students in this area. That area is missing. Nobody talks about the bond between the doctor and the patient. The students care for us. It's not fair to look at the students and the patient but the patient and the doctor" – P1*

## 5.5. Summary of Findings

From the findings, it can be shown that the students have their own unique interactional practices to accommodate to different patients with different personality traits and attributes. It also reveals communicative challenges and the students' approaches in

addressing these challenges. In sum, interviews with the patients reveal that they are satisfied with how they are both communicatively and clinically treated by their attending students. Most of the patients claim their attending dental students as the healthcare providers in the setting as caring, polite and friendly. As Leech (2014) claims, politeness is not essential and obligatory and there could be individuals who may choose to be impolite in any circumstances, but findings show that these students use proper address forms suiting their patient's social traits and needs. They also hold their responsibility professionally and ethically in the setting despite the inevitable challenges that come along during the clinical journey with the real patients.

Despite patients' satisfaction of the dental service catered, the students-operators mention about the communicative/interactional challenges while engaging with their patient. While the data are small, they provide in-depth understanding to these interactional practices and challenges. Being metacognitively aware of these interactional practices and challenges would enable dental practitioners to anticipate possible communicative challenges and to be more competent in interacting with patients in the near future.

Indeed, this research also shows that the majority of the interviewed dental students highlight the need to have a special communication class that can assist them interacting with different patients with different communicative/interactional needs and wants within the allotted time. This is to ensure that all parties' needs and wants regardless of their social backgrounds can adequately, further be met.

# CHAPTER 6: CONCLUSION

## 6.1. Introduction

In conclusion, the findings reveal how the FoDUM students interact and simultaneously behave in the multilingual clinical context when engaging with their patients from different social backgrounds. They are found to juggle between relational talk and task talk within the allotted time to achieve their dental professional objectives. This corresponds to the findings by McCarthy (2003), Koester (2006) & Coupland (2014) who posit that most professionals implement these talk with their clients in meeting their professional needs and goals.

## 6.2. Limitations and Recommendations

Among the limitations encountered in this study are: 1) The data source obtained for the study comprises only the first-half session (Part 1) of the dental engagement due to some inevitable reasons as previously mentioned in Chapter 3 (See Section 3.2). Recordings of the complete session of Part 1 and Part 2 would provide a more thorough finding and understanding about this particular type of general dental practice. Also, this would enable another inspection on how the students and their patient interact especially during the phase in Part 2 where the student-operator has to deliver an 'Oral Health Education' (OHE) to the patient. A detailed conclusion of the whole general dental practice as an activity type can be drawn and which would be more informative.

Next is regarding the researcher's limited access to interview the student-assistant due to their packed schedule. The pairs consisting the student-operator and student-assistant have different schedule outside the clinical practices. As mentioned in Chapter 3, the researcher is not able to interview the student- assistant but the student-operator instead (since the latter is the most active agent during the dental engagement).

Nonetheless, feedback from these student-assistants also can strongly provide rich insights regarding their engagement with the patient.

The third limitation is where the nine patients interviewed are in a rush as the engagement itself takes quite a while – thus, information acquired may be deemed not sufficient. Above all, the small sample of participants leads to the idea that the present study is not generalizable to all Malaysian dental institutions – also in terms of the perspectives regarding satisfaction and communicative challenges while undertaking clinical practice with actual patients. It is hoped that future researchers can fill in the above gaps in aiming generalizability to wider population, under the same area of study.

Additionally, another recommendation is to focus on the non-verbal aspects of the interactions as this component apart from the verbal ones, plays an important role in determining all participants' ultimate outcomes of the dental engagements despite the pragmatic aspects of the non-verbal aspects themselves (Robinson, 2006). Pragmatic study offers tools that allow an individual to scrutinize the underlying meaning of verbal and non-verbal components exhibited by a speaker that simultaneously could influence the outcomes of the interactions (Yule, 2016). As Silverman and Kinnersley (2010) point out, "non-verbal communication plays a significant role throughout the medical interview and is an important variable in doctor-patient interactions". An incorporation of quantitative analysis (mixed-method design) also could assist in producing a more reliable and useful study regarding participants' interactional practices.

# REFERENCES


Abu Kasim, N. H., Abu Kassim, N. L., Razak, A. A. A., Abdullah, H., Bindal, P., Che' Abdul Aziz, Z. A., Abdul Aziz, A. (2014). Pairing as an instructional strategy to promote soft skills amongst clinical dental students. *European Journal of Dental Education*, *18*(1), 51–57. https://doi.org/10.1111/eje.12058

Agar, M. H. (1985). Speaking of Ethnography. *Sage University Paper Series on Qualitative Research Methods*. https://doi.org/10.4135/9781412985895

Al-Mobeeriek, A. (2012). Dentist-patient communication as perceived by patients in Riyadh, Saudi Arabia. *International Journal of Occupational Medicine and Environmental Health*. https://doi.org/10.2478/s13382-012-0001-2

Arora, N. K. (2003). Interacting with cancer patients: The significance of physicians' communication behavior. *Social Science and Medicine*. https://doi.org/10.1016/S0277-9536(02)00449-5

Aruguette, M. S. & Roberts, C. A. (2000). Gender, Affliation and Control in Physician-Patient Encounters. *42* (1), 107-118. https://doi.org/10.1023/A:1007036412480

Atkinson, P. (1999). Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings. *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings*. https://doi.org/10.1353/lan.2001.0180

Baron, N. S. (2007). Discourse Structures in Instant Messaging: The Case of Utterance Breaks. *Discourse*.

Benbassat, J., & Baumal, R. (2002). A step-wise role playing approach for teaching patient counseling skills to medical students. *Patient Education and Counseling*. https://doi.org/10.1016/S0738-3991(01)00150-1

Ben-Sira Z. (1980). Affective and Instrumental Components in the Physician-Patient Relationship: An Additional Dimension of Interaction Theory. *Journal of Health and Social Behavior,* 170-180

Bensing, J. (1991). Doctor-patient communication and the quality of care. *Social Science and Medicine*. https://doi.org/10.1016/0277-9536(91)90047-G

Bensing, J. (2000). Bridging the gap: The separate worlds of evidence based medicine and patient centred medicine. *Patient Education and Counselling*, *39*, 17–25. https://doi.org/10.1016/S0738-Get

Bensing, J., Zandbelt, L., & Zimmermann, C. (2003). Introduction. Sequence analysis of patient-provider interaction. In *Epidemiologia e Psichiatria Sociale* (Vol. 12, pp. 78–80). https://doi.org/10.1017/S1121189X00006114

Berkhof, M., van Rijssen, H. J., Schellart, A. J. M., Anema, J. R., & van der Beek, A. J. (2011). Effective training strategies for teaching communication skills to physicians: An overview of systematic reviews. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2010.06.010

Bhattacherjee, S., Ray, K., Kumar Roy, J., Mukherjee, A., Roy, H., & Datta, S. (2016). Job Satisfaction among Doctors of a Government Medical College and Hospital of Eastern India . *Nepal Journal of Epidemiology*, *6*(3), 596–602. http://doi.org/10.3126/nje.v6i3.14762

Billings, J. A., & Stoeckle, J. D. (1977). Pelvic examination instruction and the doctor-patient relationship. *Academic Medicine*. https://doi.org/10.1097/00001888-197710000-00006

Boxer, D. (2002). Discourse issues in cross-cultural pragmatics. *Annual Review of Applied Linguistics*. https://doi.org/10.1017/S0267190502000089

Boyd, E. and Heritage, J. (2006) Taking the history: Questioning during comprehensive history-taking. In J. Heritage and D. W. Maynard (eds) *Communication in Medical Care: Interaction between Primary Care Physicians and Patients*, 151–184. Cambridge: Cambridge University Press.

Bredart, A., Bouleuc, C., & Dolbeault, S. (2005). Doctor-patient communication and satisfaction with care in oncology. *CURRENT OPINION IN ONCOLOGY*. https://doi.org/00001622-200507000-00007 [pii]

Brennan, N., Barnes, R., Calnan, M., Corrigan, O., Dieppe, P., & Entwistle, V. (2013). Trust in the health-care provider-patient relationship: A systematic mapping

review of the evidence base. *International Journal for Quality in Health Care*. https://doi.org/10.1093/intqhc/mzt063

Brown, G. & Yule, G. (1986). Discourse Analysis. Cambridge: Cambridge University Press, 89

Brown, P., & Levinson, S. (1987). Politeness: Some Universals in Language Use. *Studies in Interactional Sociolinguistics 4*. https://doi.org/10.2307/3587263

Brown, R. & M. Ford (2003). Address in American English. *Journal of Abnormal Social Psychology*, 62, 375-85

Bub, B. (2004). The patient's lament: Hidden key to effective communication: How to recognise and transform. *Medical Humanities*. https://doi.org/10.1136/jmh.2004.000164

Bucholtz, M., & Hall, K. (2005). Identity and interaction: A sociocultural linguistic approach. *Discourse Studies*. https://doi.org/10.1177/1461445605054407

Kerbrat-Orecchioni, C., & Traverso, V. (2004). Types d'interactions et genres de l'oral. *Langages*. https://doi.org/10.3917/lang.153.0041

Carey, J.A., Madill, A., & Manogue, M. (2010). Communications skills in dental education: a systematic research review. European Journal of Dental Education, 14, 69-78.

Cassel, E.J. (1985). Talking with Patients: Clinical Technique. The Massachusetts Institute of Technology

Černý, M. (2010). INTERRUPTIONS AND OVERLAPS IN DOCTOR–PATIENT COMMUNICATION REVISITED. *Linguistica Online*, *13*(4). https://doi.org/ISSN 1801-5336

Chandra, Amitabh and Douglas O. Staiger. (2007). Productivity Spillovers in Healthcare: Evidence from the Treatment of Heart Attacks. *Journal of Political Economy*.

Chang, C. L., Park, B. K., & Kim, S. S. (2013). Conversational analysis of medical discourse in rehabilitation: A study in Korea. *The Journal of Spinal Cord Medicine*, *36*(1), 24–30. http://doi.org/10.1179/2045772312Y.0000000051

Chatten, K., Howe, M., Marks, G., Smith, T., & Noble, L. (2013). MBBS Year 4 GUIDE TO HISTORY TAKING AND EXAMINATION 2012-2013. *UCL Guide To*.

Chipidza, F. E., Wallwork, R. S., & Stern, T. A. (2015). Impact of the Doctor-Patient Relationship. *The Primary Care Companion for CNS Disorders*, *17*(5), 10.4088/PCC.15f01840. http://doi.org/10.4088/PCC.15f01840

Clealand, J., de la Croix A., Cotton, P., Coulls, S., (2013). Student-patient communication during physical examination. Blackwell Publishing. doi: 10.1111/j.1743-498X.2012.00620.x.

Collins, L. G., Schrimmer, A., Diamond, J., & Burke, J. (2011). Evaluating verbal and non-verbal communication skills, in an ethnogeriatric OSCE. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2010.05.012

Corcoran, N. (2007). Theories and models in communicating health messages. *Communicating Health: Strategies for Health Promotion*, 5–31. https://doi.org/10.1212/01.CON.0000443830.87636.9a

Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *BMJ*. https://doi.org/10.1136/bmj.39246.581169.80

Coulthard, M. (1992). *Advances in Spoken Discourse Analysis*. *Arts Language and Literature*.

Coupland, J. (2000). Small Talk. Harlow. Pearson Education Limited.

Coupland. (2002). Small Talk. *Cell*, *109*(November), 421–424. https://doi.org/10.1016/S0092-8674(02)00749-3

Coupland, J. (2003). Small Talk: Social Functions. *Research on Language & Social Interaction*, *36*(1), 1–6. https://doi.org/10.1207/S15327973RLSI3601

David, M.K. McLellan, J. Rafik-Galea S. Ain Nadzimah Abdullah. (2009). Code-switching in Malaysia. Peter Lang Pub Inc.

Desjarlais-Deklerk, K., & Wallace, J. E. (2013). Instrumental and socioemotional communications in doctor-patient interactions in urban and rural clinics. *BMC Health Services Research*. https://doi.org/10.1186/1472-6963-13-261

Diette, G. B., Patino, C. M., Merriman, B., Paulin, L., Riekert, K., Okelo, S., … Rand, C. (2007). Patient factors that physicians use to assign asthma treatment. *Archives of Internal Medicine*, *167*(13), 1360–1366. https://doi.org/10.1001/archinte.167.13.1360

DiMatteo, M. R. (1998). The role of the physician in the emerging health care environment. *The Western Journal of Medicine*.

Drew, P., & Heritage, J. (1992). Analyzing talk at work: an introduction. In *Talk at work: Interaction in institutional settings* (pp. 3–65). https://doi.org/konversationsanalyse

Drew, J., Stoeckle, J. D., & Billings, J. A. (1983). Tips, status and sacrifice: Gift giving in the doctor-patient relationship. *Social Science and Medicine*. https://doi.org/10.1016/0277-9536(83)90343-X

F., Gan, A., David, M.K., & Dumanig, (2015) *Politeness Strategies and Address Forms Used by Filipino Domestic Helpers in Addressing Their Malaysian Employers.* Language in India, 15. Retrieved from, http://languageinindia.com/jan2015/ariespoliteness.pdf

Faller, E.M., Dumanig, F.P., Delli, R.M., Cruz-Bacayo, M.F.D., Pauline, L.S.M. (2015). Language Choice and Accommodation Strategies in Pharmacist-Patient Interaction in Ambulatory Care Pharmacy Service. Retrieved from https://www.researchgate.net/profile/Erwin_Faller2/publication/279203359_Language_Choice_and_Accommodation_Strategies_in_Pharmacist-Patient_Interaction_in_Ambulatory_Care_Pharmacy_Service/links/55901fd908aed6ec4bf655d9.pdf

Farzadnia, S., & Giles, H. (2015). Patient-Provider Health Interactions: A Communication Accommodation Theory Perspective. *International Journal of Society, Culture & Language*.

Foronda, C., MacWilliams, B., & McArthur, E. (2016). Interprofessional communication in healthcare: An integrative review. *Nurse Education in Practice*. https://doi.org/10.1016/j.nepr.2016.04.005

Foucalt, M. (1972). The birth of the clinic: An archaeology of medical perception. New York: Vintage Books

Foucault, M. (1981). The Order of Discourse. In *Untying the text: A post-structuralist reader* (pp. 48–78). https://doi.org/10.1177/053901847101000201

Freeman, R. (1999). The psychology of dental patient care. 2.A psychodynamic understanding of the dentist-patient interaction. *Br Dent J*, *186*(10), 503–506. https://doi.org/10.1038/sj.bdj.4800152

Gee, J. P. (2008). An introduction to discourse analysis. Theory and method. London: Routledge

Ghilzai, S. A. (2015). Conversational Analysis of Turn Taking Behavior and Gender Differences in Multimodal Conversation.

Giroldi, E., Veldhuijzen, W., de Leve, T., van der Weijden, T., Bueving, H., & van der Vleuten, C. (2015). "I still have no idea why this patient was here": An exploration of the difficulties GP trainees experience when gathering information. *Patient Education and Counseling*, *98*(7), 837–842. https://doi.org/10.1016/j.pec.2015.03.018

Glynn, M. A., Taylor, J. R., & van Every, E. J. (2002). The Emergent Organization: Communication as Its Site and Surface. *Administrative Science Quarterly*. https://doi.org/10.2307/3094898

Goodwin, C. (2000). Action and embodiment within situated human interaction. *Journal of Pragmatics*. https://doi.org/10.1016/S0378-2166(99)00096-X

Goffman, E. (1981). "Footing" in Forms of Talk. *Forms of Talk*, 124–159. https://doi.org/10.1007/s10670-009-9207-5

Goldberg, J. A. (1990). INTERRUPTING THE DISCOURSE ON INTERRUPTIONS AIt~ Analysis in Terms of Relationaliy Neutral, Power-and Rapport-Oriented. *Journal of Pragmati:s*, 4–883. https://doi.org/10.1016/0378-2166(90)90045-F

Gonzalez, M. A. G., Abu Kasim, N. H., & Naimie, Z. (2013). Soft skills and dental education. *European Journal of Dental Education*, *17*(2), 73–82. https://doi.org/10.1111/eje.12017

Green, D. W., & Wei, L. (2016). Code-switching and language control. *Bilingualism*. https://doi.org/10.1017/S1366728916000018

Gunter Senft. (2012). Phatic communion. *Max Planck Institute for Psycholinguistics*. https://doi.org/10.1075/hoph.2.20sen

Ha, J. F., & Longnecker, N., Anat DS (2010). Doctor-patient communication: a review. *The Ochsner Journal*, *10*(1), 38–43. https://doi.org/10.1043/toj-09-0040.1

Haji, O. A. B. (1985). Patterns of language communication in Malaysia. *Asian Journal of Social Science*. https://doi.org/10.1163/080382485X00039

Hall, K., & Nilep, C. (2015). Code-Switching, Identity, and Globalization. In *The Handbook of Discourse Analysis*. https://doi.org/10.1002/9781118584194.ch28

Herdina, P. & U. Jessner (2002). A dynamic model of multilingualism: Perspectives of change in psycholinguistics. Clevedon: Multilingual Matters

Heritage, J. (2005). Conversation analysis and institutional talk. *Handbook of Language and Social Interaction*. https://doi.org/10.1207/S15327973RLSI321&2_9

Heritage, J. (1997). Conversation Analysis and Institutional Talk: analysing data. In *Qualitative Research: Theory, Method and Practice* (pp. 161–182). https://doi.org/konversationsanalyse;qualitative methoden

Heritage, J., & Maynard, D. W. (2006). *Communication in Medical Care*. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients* (Vol. 9780521621). https://doi.org/10.1017/CBO9780511607172

Hofstede, G. (1984). Cultural dimensions in management and planning. *Asia Pacific Journal of Management*. https://doi.org/10.1007/BF01733682

Holden, a. (2011). Lost in transition - changes in communication in the leap from dental student to foundation dentist. *British Dental Journal*, *211*(10), 459–61. https://doi.org/10.1038/sj.bdj.2011.962

Holmes, J., & Marra, M. (2004). Relational Practice in the Workplace: Women's Talk or Gendered Discourse? *Language in Society*. https://doi.org/10.1017/S0047404504043039

Holmes, J. (2008). An introduction to sociolinguistics. Harlow, England: Pearson Longman

Holmes, J. (2011). Workplace Discourse. *Contemporary Sociology*, *40*(3), 322–324. https://doi.org/10.1177/0094306110404515x

Holt, V. P., & McHugh, K. (1997). Factors influencing patient loyalty to dentist and dental practice. *British Dental Journal*. https://doi.org/10.1038/sj.bdj.4809512

House, J., & Rehbein, J. (2004). What is 'multilingual communication'? In J. House, & J.

Rehbein (Eds.), *Multilingual communication: Hamburg studies on multilingualism 3*, 1–17. Amsterdam: John Benjamins

Hudak, P. L., & Maynard, D.W. (2008). Small talk, high stakes: Interactional disattentiveness in the context of prosocial doctor-patient interaction. *Language in Society*. https://doi.org/10.1017/S0047404508080986

Hudak, P. L., & Maynard, D. W. (2011). An interactional approach to conceptualising small talk in medical interactions. *Sociology of Health and Illness*, *33*(4), 634–653. https://doi.org/10.1111/j.1467-9566.2011.01343.x

Hyland, K. (2013). Student perceptions of hidden messages in teacher written feedback. *Studies in Educational Evaluation*. https://doi.org/10.1016/j.stueduc.2013.06.003

Hymes, D. (1972). On communicative competence. *Sociolinguistics*. https://doi.org/10.1007/s11606-007-0364-4

James, D., & Clarke, S. (1993). Women, men and interruptions: A critical review. In *Gender and Conversational Interaction*. https://doi.org/10.1017/S0272263100009967

Jan, J. M. (2003). Code-switching for power wielding: Inter-gender discourse at the workplace. *Multilingua*. https://doi.org/10.1515/mult.2003.003

Jaworski, A., & Coupland, N. (2014). The discourse reader. New York: Routledge

J César Félix-Brasdefer. (2015). The Language of Service Encounters: A Pragmatic-Discursive Approach, Cambridge: Cambridge University Press

Jefferson, G. (2004). "At first I thought." *Conversation Analysis Studies from the First Generation*.

Johns, A., & Félix-Brasdefer, J. C. (2015). Linguistic politeness and pragmatic variation in request production in Dakar French. *Journal of Politeness Research*, *11*(1), 131–164. https://doi.org/10.1515/pr-2015-0006

Johnstone, B. (2008). *Discourse analysis*. *Introducing linguistics: 3*. Retrieved from https://ezp.lib.unimelb.edu.au/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=cat00006a&AN=melb.b3137036&site=eds-live&scope=site%5Cnhttp://www.loc.gov/catdir/toc/ecip077/2006103247.html

Johnstone, B. (2008). Discourse Analysis and Narrative. In *The Handbook of Discourse Analysis* (pp. 635–649). https://doi.org/10.1002/9780470753460.ch33

Keltner, D., Capps, L., Kring, A. M., Young, R. C., & Heerey, E. A. (2001). Just Teasing: A Conceptual Analysis and Empirical Review. *Psychological Bulletin*. https://doi.org/10.1037/0033-2909.127.2.229

Koester, A. (2006). Investigating workplace discourse. *Investigating Workplace Discourse*, 1–183. https://doi.org/10.4324/9780203015742

Kotler, D. P. (2003). HIV infection and lipodystrophy. *Progress in Cardiovascular Diseases*. https://doi.org/10.1053/pcad.2003.2

Lave, J., & Wenger, E. (1991). *Situated learning: legitimate peripheral participation. 1991*. *Man*. https://doi.org/10.2307/2804509

Lee, L. M., Wright, B., & Semaan, S. (2013). Expected ethical competencies of public health professionals and graduate curricula in accredited schools of public health in North America. *American Journal of Public Health*. https://doi.org/10.2105/AJPH.2012.300680

Leech, G. (2014). *The Pragmatics of Politeness*. *The Pragmatics of Politeness*. https://doi.org/10.1093/acprof:oso/9780195341386.001.0001

Lerner, G. H. (2004). Collaborative turn sequences. *Conversation Analysis: Studies from the First Generation*. https://doi.org/10.1075/pbns.125.12ler

Littlejohn, S. W., & Foss, K. a. (2008). Communication Theory and Scholarship. *Theories of Human Communication*, 2–11. Retrieved from http://www.cengagebrain.com/shop/content/littlejohn95877_0495095877_02.01_chapter01.pdf

Mahrous, M. S., & Hifnawy, T. (2012). Patient satisfaction from dental services provided by the College of Dentistry, Taibah University, Saudi Arabia. *Journal of Taibah University Medical Sciences*. https://doi.org/10.1016/j.jtumed.2012.12.002 Malaysian Dental Council. Annual Report 2011. Cyberjaya: Malaysian Dental Council; 2012.

Mathew, T., Shetty, A., Shetty, C., Narasimhan, D., Shetty, S., & Hegde, M. N. (2015). Comparison of communication skills between undergraduate dental students with and without prior training in effective communication. *Nitte University Journal of Health Science*.

Matusitz, J., & Spear, J. (2014). Effective doctor-patient communication: An updated examination. *Social Work in Public Health*, *29*(3), 252–266. https://doi.org/10.1080/19371918.2013.776416

Mazeland, H. (2006). Conversation analysis. In *Encyclopedia of language and linguistics*. https://doi.org/10.1007/s10339-011-0417-9

McCarthy, M. (1993). Spoken discourse markers in written texts. In *Techniques of description: Spoken and written discourse*.

McCarthy, M. (2000). Discourse Analysis for Language Teachers. Cambridge: Cambridge University Press.

McCarthy, M.C. (2003a). Detecting acute confusion in older adults: Comparing clinical reasoning of nurses working in acute, longterm and community health care environments. Research in Nursing and Health, 26, 203-212.

McCarthy, M. et al. (2006) Touchstone. Textbook series. Cambridge: Cambridge University Press.

Morais, E. (1998). "Language choice in a Malaysian car-assembly plant". *International Journal of the Sociology of Language*, 130, 89–105.

Morreall, J. (1991). Humor and work. *Humor*. https://doi.org/10.1515/humr.1991.4.3-4.359

Miller, D. (1996). A preliminary typology of organizational learning: Synthesizing the literature. *Journal of Management*. https://doi.org/10.1016/S0149-2063(96)90033-1

Mishler, E. (1984). Discourse of Medicine: Dialectics of Medical Interviews. Norwood. NJ: Ablex.

Ministry of Health Malaysia. Health Facts 2012. Health Informatics Centre, Planning and Development Division. Malaysia: Ministry of Health; 2013.

Memarpour, M., Bazrafkan, L., & Zarei, Z. (2016). Assessment of dental students' communication skills with patients. *Journal of Advances in Medical Education & Professionalism*, *4*(1), 33–8. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4711814&tool=pmcentrez&rendertype=abstract

Mills, S. (2004). *Discourse*. *New critical idiom*.

Myers-Scotton, C. (2005). Supporting a Differential Access Hypothesis: Code Switching and Other Contact Data. In *Handbook of bilingualism: Psycholinguistic approaches.*

Newton, J. T. (1995). Dentist/patient communication: a review. *Dental Update*, *22*, 118–122.

Nor, N. A. M., Yusof, Z. Y. M., & Shahidan, M. N. F. M. (2011). University of Malaya dental students' attitudes towards communication skills learning: implications for dental education. *Journal of Dental Education*, *75*(12), 1611–1619.

Novoa, A. (2015). "Code-Switching in a Multilingual Workplace". *The Journal of undergraduate ethnography*. *12* (3).

O'Hair, D. [Ed], & Kreps, G. L. [Ed]. (2013). Applied communication theory and research. *Applied Communication Theory and Research.* Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc3&NEWS=N&AN=1990-98545-000

Ojha, A. K., & Holmes, T. L. (2010). Don ' t Tease Me , I ' m Working : Examining Humor in a Midwestern Organization Using Ethnography of Communication. *The Qualitative Report*.

Ong, L. M. L., De Haes, I. J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Pergamon DOCTOR-PATIENT COMMUNICATION: A REVIEW OF THE LITERATURE. *Soc. Sci. Med*, *40*(7), 903–918. https://doi.org/10.1016/0277-9536(94)00155-M

Ong, L. M., de Haes, J. C., Hoos, a M., Lammes, F. B., Hospital, A. M., & Hospital, A. M. (1995). Doctor-patient communication: a review of the literature. *Social Science & Medicine (1982)*, *40*(7), 903–18. https://doi.org/10.1016/0277-9536(94)00155-M

Pierret, J. (2003). The illness experience: state of knowledge and perspectives for research. *Sociology of Health & Illness*. https://doi.org/10.1111/1467-9566.t01-1-00337

Pitceathly, C., & Maguire, P. (2003). The psychological impact of cancer on patients' partners and other key relatives: A review. *European Journal of Cancer*. https://doi.org/10.1016/S0959-8049(03)00309-5

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. *Sage Publications Ltd.*

Purtilo, R.B., Haddad, A.M., Doherty, R.F. (2014). *Health Professional and Patient Interaction. Elsevier Inc.*

Ragan, S. L. (2000). 'Social talk in women's health care contexts: two forms of non-medical talk', in Coupland J. (ed.) (2000). Harlow, Essex: Pearson

Ranjan, P., Kumari, A., & Chakrawarty, A. (2015). How can doctors improve their communication skills ? *Journal of Clinical Diagnostic Research*. https://doi.org/10.7860/JCDR/2015/12072.5712

Rider, E. A., & Keefer, C. H. (2006). Communication skills competencies: Definitions and a teaching toolbox. *Medical Education*. https://doi.org/10.1111/j.1365-2929.2006.02500.x

Riehl, C. M. (2005). Code-switching in Bilinguals : Impacts of Mental Processes and Language Awareness. *The 4th International Symposium on Bilingualism*, 1945–1959. Retrieved from http://www.lingref.com/isb/4/151ISB4.PDF

Roberts, C., & Sarangi, S. (2005). Theme-oriented discourse analysis of medical encounters. *Medical Education*, *39*(6), 632–640. https://doi.org/10.1111/j.1365-2929.2005.02171.x

Robinson, R. G. (2006). *The clinical neuropsychiatry of stroke: Second edition*. *The Clinical Neuropsychiatry of Stroke*. https://doi.org/10.1017/CBO9780511544231

Robinson, J. D., & Heritage, J. (2006). Physicians' opening questions and patients' satisfaction. In *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2005.11.009

Roter, D. (1983). Physician/patient communication. Transmission information and patient effects. *Maryland State Medical Journal, 32*, 260-265.

Sacks, H., Schegloff, E., & Jefferson, G. (1974). A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language*, *50*(4), 696–735. https://doi.org/10.2307/412243

Sacks, H. (2010). *Lectures on Conversation*. *Lectures on Conversation*. https://doi.org/10.1002/9781444328301

Salmon, P., & Young, B. (2011). Creativity in clinical communication: From communication skills to skilled communication. *Medical Education*. https://doi.org/10.1111/j.1365-2923.2010.03801.x

Sami Ali Nasr Al-Wossabi. (2016). "A Conversational Analysis Model for Promoting Practices of Interactional Competence in the EFL Context". *International Journal of English Linguistics*. *6*(6), 32-44.

Sanders, A. E., Spencer, A. J., & Stewart, J. F. (2005). Clustering of risk behaviours for oral and general health. *Community Dental Health*.

Sarangi, S. (2004). Institutional, professional, and lifeworld frames in interview talk. In *Analyzing Race Talk: Multidisciplinary Perspectives on the Research Interview*. https://doi.org/10.1017/CBO9780511489792.005

Sarangi, S. (2004). Towards a communicative mentality in medical and healthcare practice. *Communication & Medicine*, *1*(1), 1–11. https://doi.org/10.1515/come.2004.002

Sarangi, S. (2005). The conditions and consequences of professional discourse studies. *Journal of Applied Linguistics*. https://doi.org/10.1558/japl.v2i3.371

Sarangi, S. (2010). Reconfiguring self/identity/status/role: The case of professional role performance in healthcare encounters. *Journal of Applied Linguistics and Professional Practice*. https://doi.org/10.1558/japl.v7i1.75

Sarangi, S., & Roberts, C. (1999). The dynamics of interactional and institutional orders in work-related settings. *Talk, {Work} and {Institutional} {Order}: {Discourse} in {Medical}, {Mediation} and {Management} {Settings}*, 160.

Saville-Troike, M. (2003). The analysis of communicative events. In *Ethnography of Communication: An Introduction* (pp. 88–143). https://doi.org/10.1002/9780470758373.ch4

Saville-Troike, M. (2008). *The Ethnography of Communication: An Introduction: Third Edition*. *The Ethnography of Communication: An Introduction: Third Edition*. https://doi.org/10.1002/9780470758373

Schegloff, E. A. (2001). Discourse as an Interactional achievement III: The omni-relevance of action. In: Schiffrin, D., Tannen, D. and Hamilton, H. (Eds.). *The hand book of discourse analysis* (pp. 229-249). Oxford: Blackwell Publishers Ltd.

Schegloff, E. A. (2007). *Sequence organization in interaction: A primer in conversation analysis I*. *Sequence Organization in Interaction: A Primer in Conversation Analysis I*. https://doi.org/10.1017/CBO9780511791208

Schiffrin, D., Tannen, D. and Hamilton, H. (Eds.) (2001). *The handbook of discourse analysis*. Oxford: Blackwell Publishers Ltd.

Schiffrin, D., Tannen, D., & Hamilton, H. E. (2008). *The Handbook of Discourse Analysis*. *The Handbook of Discourse Analysis*. https://doi.org/10.1002/9780470753460

Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2005.11.014

Searle, J. R. J. (1969). Speech acts: An essay in the philosophy of language. *East*. https://doi.org/http://dx.doi.org/10.1017/CBO9781139173438

Shaw, S., & Bailey, J. (2009). Discourse analysis: What is it and why is it relevant to family practice? *Family Practice*. https://doi.org/10.1093/fampra/cmp038

Shigli, K., & Awinashe, V. (2010). Patient-dentist communication: An adjunct to successful complete denture treatment. *Journal of Prosthodontics*. https://doi.org/10.1111/j.1532-849X.2010.00597.x

Sidnell, J. (2012). Basic Conversation Analytic Methods. In *The Handbook of Conversation Analysis* (pp. 77–99). https://doi.org/10.1002/9781118325001.ch5

Silverman, J., Kurtz, S., & Draper, J. (2005). *Skills for communicating with patients*. *Communication*. https://doi.org/10.1111/j.1369-7625.2005.00329.x

Silverman, J., & Kinnersley, P. (2010). Doctors' non-verbal behaviour in consultations: Look at the patient before you look at the computer. *British Journal of General Practice*. https://doi.org/10.3399/bjgp10X482293

Simpson, M., Buckman, R., Stewart, M., Maguire, P., Lipkin, M., Novack, D., & Till, J. (1991). Doctor-patient communication: the Toronto consensus statement. *BMJ*. https://doi.org/10.1136/bmj.303.6814.1385

Siregar, M., Bahri, S., & Sanjaya, D. (2014). Code Switching and Code Mixing in Indonesia: Study in Sociolinguistics? *English Language and Literature Studies*. https://doi.org/10.5539/ells.v4n1p77

Stewart, M., Brown, J. B., Boon, H., Galajda, J., Meredith, L., & Sangster, M. (1999). Evidence on patient-doctor communication. *Cancer Prevention & Control : CPC = Prévention & Contrôle En Cancérologie : PCC*, *3*(1), 25–30. https://doi.org/10.1158/1940-6207.PREV-09-A25

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L., & Freeman, T. R. (1995). Patient-centered medicine: Transforming the clinical method. Thousand Oaks, CA, US: Sage Publications, Inc.

Street, R. L. (1991). Information-giving in the medical consultations: The influence of patients' communication styles and personal characteristics. *Social Science Medicine* 32 (5)**:** 541- 548.

Stewart, M. (2005). Reflections on the doctor-patient relationship: From evidence and experience. *British Journal of General Practice.*

Stubbs, M. (1983). *Discourse Analysis: A Sociolinguistic Analysis of Natural Language*. Oxford: Blackwell Publishers Ltd.

Teh,I., Chu,C.(2005). Supplementing Growth with Medical Tourism. *Asia Pacific Biotech News (Special Report: Medical Tourism).*

Tonio S, Joerg K, Joachim K. (2011) Determinants of patient satisfaction: a study among 39 hospitals in an in-patient setting in Germany. *International Journal for Quality in Health Care*, Vol ;23(5):503-509 .10.1093/intqhc/mzr038

Traynor, M. (2006). Discourse analysis: Theoretical and historical overview and review of papers in the Journal of Advanced Nursing 1996-2004. *Journal of Advanced Nursing*. https://doi.org/10.1111/j.1365-2648.2006.03791.x

Valencia, D. (2009). "No offense guys": Some ambiguous functions of small talk and politeness in workplace discourse. 17-32

Van Rijssen, H. J., Schellart, A. J. M., Anema, J. R., & Van Der Beek, A. J. (2009). A theoretical framework to describe communication processes during medical disability assessment interviews. *BMC Public Health*. https://doi.org/10.1186/1471-2458-9-375

Watts, R. J. (2003). *Politeness*. *Key topics in sociolinguistics*. https://doi.org/DOI: 10.1017/CBO9780511615184

Wardhaugh, R. (2010). An introduction to sociolinguistics. (6th Ed). UK: Wiley-Blackwell.

Waylen, A., Makoul, G., & Albeyatti, Y. (2015). Patient-clinician communication in a dental setting: A pilot study. *British Dental Journal*. https://doi.org/10.1038/sj.bdj.2015.389

Wears, R. L., & Perry, S. J. (2010). Discourse and Process Analyses of Shift Change Handoffs in Emergency Departments. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting*. https://doi.org/10.1177/154193121005401232

Weiner, J. P. (2012). Doctor-patient communication in the e-health era. *Israel Journal of Health Policy Research*. https://doi.org/10.1186/2045-4015-1-33

Wener, M. (2011). Immune Complexes in Systemic Lupus Erythematosus. In *Systemic Lupus Erythematosus: Ed. Tsokos, G. – 2011*.

Wenger, E. (1998). Communities of Practice : Learning as a social system. *Systems Thinker*. https://doi.org/10.2277/0521663636

Wetherel, M., & Potter, J. (1998). Discourse and Social Psychology--Silencing binaries. Jun 1998. *Theory & Psychology*, *.8*(3), pp.

Williams, S., Weinman, J., & Dale, J. (1998). Doctor-patient communication and patient satisfaction: a review. *Family Practice*. https://doi.org/10.1093/fampra/15.5.480

Wiseman, E. F., Chatten, K., Shah, S., Keld, R. R., & Ang, Y. S. (2017). Patients' views on their experience of the delivery of single-sex accommodation within the endoscopy department: is it worth it? *Frontline Gastroenterology*, *8*(1), 13–18. http://doi.org/10.1136/flgastro-2016-100683

Witczak-Plisiecka, I. (2013). Context and contexts: Parts meet whole? *Journal of Pragmatics*. https://doi.org/10.1016/j.pragma.2013.03.005

Yoong, D. (2010). Interactional norms in the Australian police interrogation room. *Discourse and Society*. https://doi.org/10.1177/0957926510381223

Yule, G., & Stalnaker, R. (1996). Pragmatics. *Synthese*, *22*(1–2), 152. Retrieved from http://philpapers.org/rec/STAP-7%5Cnhttp://www.amazon.com/Pragmatics-Oxford-Introductions-Language-Study/dp/0194372073

Zhang, Y. (2008). Classroom Discourse and Student Learning. *Asian Social Science, 4*(9), 80–83.

Zhang, Y. (2010). Cooperative Language Learning and Foreign Language Learning and Teaching. *Journal of Language Teaching and Research.* https://doi.org/10.4304/jltr.1.1.81-83